

HOW TO SUPPORT KNOWING AND DOING IN PROMOTION OF HEALTH

Lessons learned from the Promoting Aging
Migrants' Capabilities program

Emmelie Barenfeld

Department of Health and Rehabilitation
Institute of Neuroscience and Physiology
Sahlgrenska Academy at University of Gothenburg



UNIVERSITY OF GOTHENBURG

Gothenburg 2016

Cover illustration: Grandpa with grandchildren by Johan Barenfeld

How to support knowing and doing in promotion of health

© Emmelie Barenfeld 2016

emmelie.barenfeld@gu.se

ISBN 978-91-628-9979-0 (Print)

ISBN 978-91-628-9980-6 (PDF)

<http://hdl.handle.net/2077/47404>

Printed in Gothenburg, Sweden 2016

Ineko AB

“Once we accept our limits, we go beyond them.”

Albert Einstein

HOW TO SUPPORT KNOWING AND DOING IN PROMOTION OF HEALTH

Lessons learned from the Promoting Aging Migrants' Capabilities program

Emmelie Barenfeld

Department of Health and Rehabilitation, Institute of Neuroscience and Physiology
Sahlgrenska Academy at University of Gothenburg
Göteborg, Sweden

ABSTRACT

Worldwide, the number of persons aging in the context of migration increases. Aging and migration can influence a persons' opportunities to experience health. There is a need to develop knowledge of how to facilitate implementation of evidence-based health promotion for this target group, and to evaluate the outcomes of such programs. In the context of a researcher-community partnership, this thesis aimed to explore how to support the development and realizing of an adapted health promotion program its benefits, and impact for older persons aging in the context of migration.

Methods: Different research methods were combined by performing one qualitative case study, two grounded theory studies and one randomized controlled trial. The studied sample consisted of health personnel, policymakers and researchers, and older persons aged ≥ 70 years who have migrated to Sweden from Finland or the Western Balkan region. Data were collected by: focus group discussions, individual interviews, document review, and face-to-face interviews according to a study questionnaire.

Results: The findings showed how negotiations in a researcher-community partnership supported suitable program adaptations. Reasons driving the negotiation process and actions taken to inhibit or support adaptations were identified as a result of the negotiations. In addition, the findings showed that the adapted program was experienced to raise awareness and how program content and design contributed to this. Health-promoting messages exchanged during the program were used in health decision-making in everyday life. No significant intervention effect was demonstrated on activities in daily living or self-rated health.

Conclusion: The use of a researcher-community partnership as an implementation strategy was fruitful. The adapted program bridged barriers to health promotion, and contributed to benefits in everyday life. Different findings regarding program evaluation were drawn from qualitative and quantitative findings. Therefore, further studies are needed before a final conclusion on the effect of the adapted program can be determined. Due to experienced benefits, the program is recommended for increasing the skills of older people aging in the context of migration to take advantage of rights and opportunities within health services.

Keywords: Emigration and immigration, person-centeredness, implementation, health promotion, activities of daily living, optimal aging

ISBN: 978-91-628-9979-0 (Print)

SAMMANFATTNING PÅ SVENSKA

Andelen äldre personer ökar i världen och på grund av global migration åldras allt fler utanför sitt födelseland. Både åldrande och migration kan influera förutsättningar att uppleva hälsa och en persons möjligheter att göra hälsosamma val. Äldre personer som har migrerat beskrivs därför som en viktig målgrupp för hälsofrämjande insatser. Dessa insatser bör vara baserade på forskning, beprövad erfarenheter och äldre personers erfarenheter och önskemål. Denna avhandling belyser införandet och utvärderingen av 'Senior träffar' (hälsofrämjande grupp-träffar) som tidigare visat lovande forskningsresultat.

Syftet med avhandlingen var att undersöka utveckling och implementering av ett anpassat hälsofrämjande program, liksom vilken nytta och påverkan programmet har i vardagslivet för personer 70 år eller äldre som har migrerat till Sverige från Finland eller Västra Balkan. Avhandlingen innefattar en ramberättelse och fyra delarbeten vilka studerade implementering av program innehåll och utformning. Användning av kunskap från programmet i vardagen studerades också liksom dess påverkan på vardagliga aktiviteter och hälsa. Både kvalitativa och kvantitativa ansatser användes för att besvara syftet.

Resultaten visar hur utformning och innehåll av 'Senior träffar' anpassades i samverkan mellan forskare, personal och ledningsgrupp i en verksamhet. Samverkan både stöttade och hindrade anpassningar av programmet. Resultaten visar att den kvantitativa utvärderingen av programmet inte gav någon vetenskapligt bevisad effekt på aktivitetsförmåga och hälsa. De kvalitativa studierna visade att programmet gjorde nytta. Personer som deltog i programmet upplevde att det främjade hälsa genom att de blev mer medvetna. I vardagen användes kunskap från programmet som ett stöd för hälsobeslut. Det finns flera tänkbara förklaringar till att den kvantitativa och de kvalitativa utvärderingarna visade olika resultat. Rekommendationen är att utvärdera 'Senior träffar' i en multicenter-studie och att man vänder sig till en äldre ålders grupp. Vidare bidrar resultaten med verktyg för både målgrupp och personal om hur barriärer till hälsopromotion kan överbryggas. Det möjliggör för målgruppen att få ta del av samhällets utbud för att förstå vilka möjligheter och rättigheter de har.

TIIVISTELMÄ SUOMEKSI

Iäkkäiden ihmisten määrä lisääntyy maailmassa ja globaalisesta maahanmuutosta johtuen yhä useampi vanhenee oman synnyinmaansa ulkopuolella. Sekä ikääntyminen että maahanmuuttajatausta voivat vaikuttaa edellytyksiin kokea terveyttä, sekä henkilön edellytyksiä tehdä terveellisiä valintoja. Iäkkäitä ihmisiä, joilla on maahanmuuttaja tausta, kuvaillaan siksi tärkeänä kohderyhmänä terveyttä edistävälle toimenpiteille. Näiden toimenpiteiden tuleekin perustua tutkimukseen, kokemustietoon sekä iäkkään henkilön kokemuksiin ja toiveisiin. 'Seniori tapaamiset' ovat aiemmin osoittaneet lupaavia tutkimustuloksia ja tämä väitöskirja tarjoaa lisävaloa ohjelman toteuttamiselle sekä evaluoinnille.

Tutkielman tavoite oli tarkastella sovellettua terveyttä edistävää ohjelmaa, sen kehittämistä ja implementointia, sekä ohjelman hyötyä ja vaikuttavuutta arkielämään 70 vuotta tai vanhemmille henkilöille joilla maahanmuuttotausta joko Suomesta tai Länsi-Balkanista. Tutkielma koostuu teoreettisesta viitekehyksestä sekä neljästä osatutkimuksesta, joissa tutkitaan ohjelman sisällön ja sen muodostamisen implementointia. Tarkastuksen kohteena oli myös ohjelman tuottaman tiedon hyödyntäminen arkipäivässä ja sen vaikutusta joka päiväiseen toimintaan ja terveyteen. Tutkielmaan käytettiin sekä kvalitatiivisia että kvantitatiivisia lähestymistapoja tavoitteen saavuttamiseksi.

Tulokset osoittavat miten ohjelman 'Seniori tapaamiset' muokkaus ja sisältö sovellettiin yhteistyössä tutkijoiden, henkilökunnan ja toiminnan johtoryhmän kanssa. Yhteistyö sekä tuki että esti ohjelman soveltamista. Tulokset osoittavat, että ohjelman kvantitatiivinen evaluointi ei antanut mitään tieteellisesti todistettavaa vaikutusta osallistujien toimintakyvylle tai terveydelle. Kvalitatiiviset tulokset osoittivat, että ohjelmasta on hyötyä. Henkilöt, jotka osallistuvat ohjelmaan kokivat että se edisti terveyttä siten että se lisäsi heidän tietoisuutta terveydestä. Arkipäivässä ohjelmasta saatua tietoa käytettiin tukena kun tehtiin terveyteen liittyviä päätöksiä. On olemassa monta mahdollista selitystä sille miksi kvalitatiiviset ja kvantitatiiviset tulokset erosivat toisistaan. Suositus on että 'Seniori tapaamiset' arvioidaan monikeskustutkimuksissa ja että keskityttäisiin vanhempaan ikäryhmään. Tulokset antavat työkaluja sekä kohderyhmälle että henkilökunnalle miten esteitä terveyden edistämiseksi voidaan poistaa. Se mahdollistaa kohderyhmän osallistumisen yhteiskunnan tarjontaan ja ymmärtämään mitkä oikeudet heillä on.

SAZETAK NA BALKANSKOM JEZIKU

Jedan dio starijih ljudi odrasta u svijetu i zbog globalnih migracija, stare sve više i više izvan svoje zemlje gdje su rođeni. Starenje i migracija mogu utjecati na zdravlje i sposobnost jedne osobe da izabere zdraviji život. Stariji ljudi koji su migrirali opisuju zato jednu važnu grupu za promociju zdravlja. Ovi napori treba da se zasnivaju na istraživanjima, dokazanom iskustvu i iskustva i preferencije starijih ljudi. Ovaj rad naglasava uvođenje i evaluaciju Senior sastanki (grupni susreti za zdravlje) kao što su prethodno pokazali obećavajuće rezultate za ovog istraživanja.

Cilj ovog rada je bio da istraži razvoj i implementaciju prilagođenih programa za promociju zdravlja, kao i prednosti i važnosti programa u svakodnevnom životu za ljude od 70 godina ili stariji koji su migrirali u Švedsku iz Finske i Zapadnog Balkana. Ovaj rad uključuje sveobuhvatan sažetak i četiri rada koji proučavaju realizaciju sadržaja programa i konfiguraciju. Koristenje znanje stečeno iz programa u svakodnevnom životu je također studiran, kao i njen uticaj na svakodnevne aktivnosti i zdravlje. Kvalitativne i kvantitativne pristupe korištene su odgovoriti svrha ovog rada.

Rezultati pokazuju kako je dizajn i sadržaj 'Senior sastanka' prilagođen u suradnji između istraživača, osoblja i upravljanju u poslovanju. Oni su i podržali i spriječavali prilagodavanja programa. Rezultati pokazuju da je kvantitativna evaluacija programa nije dala naučno dokazano efekt na aktivnost i zdravlje. Kvalitativna studija je pokazala da je program bio koristan. Ljudi koji su učestvovali u programu smatrali da promovise zdravlje i postali su svjesniji. U svakodnevnoj upotrebi znanja iz programa je korišten kao osnov za zdravlje odluke. Postoji nekoliko mogućih objašnjenja što je kvantitativno i kvalitativno evaluacije pokazala različite rezultate. Preporuka je da se proceni više 'Senior sastanke' u studiji multi-centar i da radi onda sa grupom što je više starija. Osim toga, pokazuju rezultati sa alatima za grupu što je bila izabrana i osoblje, kako prepreke za promociju zdravlja mogu se premostiti. To omogućava grupi da učestvuju u izboru društva da razumiju koja prava imaju.

LIST OF PAPERS

This thesis is based on the following studies, referred to in the text by their Roman numerals.

- I. Barenfeld E, Wallin L, Björk Brämberg E. Moving from Knowledge to Action in Partnership: A Case Study on Program Adaptation to Support Optimal Aging in the Context of Migration. *In manuscript.*
- II. Barenfeld E, Gustafsson S, Wallin L, Dahlin-Ivanoff S. Understanding the “black box” of a health-promotion program: Keys to enable health among older persons aging in the context of migration. *International Journal of Qualitative Studies on Health and Well-Being.* 2015;10:29013.
- III. Barenfeld E, Gustafsson S, Wallin L, Dahlin-Ivanoff S. Using Health-Promoting Messages in Decision-Making: a Grounded Theory study of the Promoting Aging Migrants’ Capabilities Program. *Submitted for publication.*
- IV. Barenfeld E, Dahlin-Ivanoff S, Wallin L, Gustafsson S. Results and lessons learned from the RCT “Promoting Aging Migrants’ Capabilities” – focusing on Activities of Daily Living and Self-Rated Health. *Submitted for publication.*

CONTENT

ABBREVIATIONS	IV
1 INTRODUCTION	1
1.1 Aging in the context of migration	2
1.2 Capabilities for optimal aging.....	4
1.3 Promoting health in a migration context	6
1.3.1 The current evidence base	7
1.3.2 Health-promoting senior meetings.....	7
1.4 From knowing to doing in partnership	8
1.5 Moving evidence to practice.....	8
1.5.1 Adapting evidence to context.....	10
1.6 Evaluating complex health-promotion programs.....	11
2 RATIONALE.....	13
3 AIMS	15
4 PARTICIPANTS AND METHODS.....	17
4.1 Overall study design.....	17
4.1.1 Methodological choices and assumptions	18
4.2 Study setting.....	19
4.2.1 Promoting Aging Migrants' Capabilities study	19
4.3 Recruitment and participants	21
4.3.1 Health-care personnel, steering committee members and researchers (study I).....	21
4.3.2 People aged ≥ 70 years who migrated from Finland or the Western Balkan region (studies II–IV).....	22
4.4 Data collection.....	25
4.4.1 Focus group discussions (study I)	25
4.4.2 Individual interviews (studies I–III).....	25
4.4.3 Document review (study I).....	27
4.4.4 The study questionnaire (study IV).....	27

4.5	Data analysis.....	28
4.5.1	Case study analysis: A two-step approach.....	28
4.5.2	A constructivist approach to Grounded Theory.....	28
4.5.3	Statistical analysis.....	29
5	ETHICAL CONSIDERATIONS	31
6	RESULTS.....	33
6.1	Negotiations as a way to support suitable program adaptations	33
6.1.1	Reasons driving the negotiation process	33
6.1.2	Actions to inhibit or support adaptations	34
6.2	Ways to raise awareness during the program.....	36
6.3	Integration of health-promoting messages in everyday life.....	38
6.4	Program effect on activities of daily living and self-rated health	40
7	DISCUSSION	43
7.1	Adapting a program in partnership	43
7.2	Contextual influences on implementation	44
7.3	Experienced benefits of PAMC.....	47
7.4	The effect of PAMC on doing and health in everyday life.....	48
7.5	Methodological considerations	50
7.5.1	Using a mixed method approach.....	50
7.5.2	Methodological challenges and contributions	51
8	CONCLUSION.....	55
9	IMPLICATIONS FOR PRACTICE AND RESEARCH.....	56
10	FUTURE PERSPECTIVES.....	57
	TACK.....	59
	REFERENCES	62

ABBREVIATIONS

ADL	Activities of Daily Living
GT	Grounded Theory
KTA	Knowledge To Action framework
LOCF	Last Observation Carried Forward
MCD	Median Change Deterioration
PAMC	Promoting Aging Migrants' Capabilities
RCT	Randomized Controlled Trial

1 INTRODUCTION

During the last few decades we have seen an increased focus on evidence-based practice (1). To provide health services that are based on research evidence, best practice and experiences of people in need of healthcare is considered a cornerstone of policy documents worldwide. This applies, not in the least, to health services for older people because they constitute an increasing proportion of the world population (2, 3). Health promotion programs are a service of value to support older people to manage their everyday lives and experience health (4-6). Aging persons might not have equal opportunities to enjoy good health. Factors of an individual, group and societal level form what a person actually can or cannot do to achieve desired health goals (7). Migration is recognized as a social determinant for health (8, 9), and to be aging in the context of migration may bring a loss of preconditions for good health, including independence in daily activities (10, 11). Implementing evidence-based health-promotion aimed to support older persons aging in the context of migration to manage their everyday life is therefore of particular importance.

Evidence-based practice has been described as beneficial (12). However, it may also lead to injustice if people with the greatest needs, such as older persons and migrants, are underrepresented or excluded from research which is often the case (13). Working according to an evidence-based manner is controlled by various conditions, is dependent on evidence being available, and that such evidence is translated into action (12, 14). That is, evidence needs both to be developed, and made available and applicable to real-case scenarios so that it can be put into action. Besides the call for evidence based practice there is also a call for person-centered approaches (2, 15, 16) which entails shared decision making (15). Thus, from a person-centered point of view three different sources of knowledge are outlined in relation to evidence-based practice, all of which are essential and complementary: the health professionals' expertise, the expertise of the people we encounter in health services, and research evidence (15, 17).

The Promoting Aging Migrants' Capabilities (PAMC) study (18), which includes this thesis, aimed to implement a person-centered approach to health-promotion 'senior meetings' in a researcher-community partnership. Senior meetings were originally developed with and for independent-living persons aged ≥ 80 years (19), and have shown promising results for a range of outcomes in both the short and long term for older people from Sweden

(4, 20-22). The PAMC study's central goal was therefore to translate evidence from 'senior meetings' and to evaluate if the PAMC could support optimal aging among older people who have migrated to Sweden from Finland or the Western Balkan region. This thesis is therefore located and has evolved in the "gray area" between intervention and implementation research.

Intervention research aims to evaluate how intervention contributes to evidence-based knowledge by capture the value and differential effect of interventions (23). Implementation research aims instead to present the results of strategies that can be used to support the introduction of evidence-based knowledge into practice (24). This thesis includes studies aimed at exploring both the implementation (i.e. realization) of PAMC's content and design (I–II), as well as the integration of obtained knowledge from the program into everyday life (III) and its effects on daily activities and health (IV).

The four included articles can be considered as different pieces of a puzzle that answer the question: How to support knowing and doing in promotion of health? 'Knowing' refers to both "know that" (descriptive) and "know how" (action-based), and evidence is regarded as a subset (shape) of knowledge (25). 'Doing' refers to both performed actions during program development, implementation and performance of PAMC as well as occupations in the older peoples' everyday lives. Background on the following topics will be provided hereafter to form a theoretical basis for understanding the prerequisites required for supporting knowing and doing: aging in the context of migration, capabilities for optimal aging, promoting health in a migration context, moving evidence to practice, and evaluating complex programs

1.1 Aging in the context of migration

Societal changes such as aging populations and global migration have seen an increasing number of people aging in the context of migration worldwide (26). There are now more people than in the past who have migrated from their country of birth to reside in another country. These people therefore experience the aging process in their adopted country, an experience that might entail both similarities and differences between persons. To age in the context of migration poses different challenges to people depending on factors such as age at migration, migration motives, cultural background, educational levels and current socioeconomic status (27). In Sweden, approximately 12% of all people aged ≥ 65 years are born abroad (28). One

reason why the proportion of older people born abroad is currently rising in Sweden is related to the country's migration history. Migration to Sweden was intensified in the mid-1900s because of industrialization and the need for labor, and continued through to the 1970s. Migration is now dominated by an influx of refugees as a result of war, and political and social turbulence in many other parts of the world (29). Labor immigrants represent the largest proportion of older people who have migrated to Sweden. Therefore, many older people who have migrated to Sweden have lived here for more than 20 years; the majority of whom (86%) were born in one of the Nordic countries or in Europe (30).

Various theories on aging exist, and what is meant by aging and being an older person may differ depending on the chosen perspective (31). Chronological age is one way of defining whether a person is old. In Sweden, and in many Western countries, people aged ≥ 65 years are regularly referred to as older adults owing to the standard retirement age (32). However, the meaning of aging is more complex than a number on a piece of paper. Previous literature have shown that perceptions of aging are influenced by subjective experiences, which in turn are influenced by a persons' individual and cultural context (31, 33, 34). Thus, aging can be described as a complex interaction between biological, psychological and social processes (2, 31).

Both age and migration may contribute to frailty (35, 36); a diminished ability to respond to stress results in one becoming vulnerable to poorer health outcomes. Different definitions of frailty exist (36); one where the concept encompasses only physical components (37), and the other a multidimensional view that incorporates social components (38, 39). Fried et al. (37) describe physical frailty components such as unintentional weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, and weak grip strength. Tiredness in daily activities, low vision, or poor balance have also been considered as frailty indicators (40), and are incorporated in the view of physical frailty applied in this thesis.

Frailty increases with age (37), and can be influenced by both the conditions in the country of birth and in the country people reside in after migration (35). Reaching out to older people with health-promoting interventions before they become frail is important for supporting older people in managing their everyday lives (41). Missed opportunities to benefit from positive contributions to health in the country of residence might explain the higher levels of frailty found among older people who have migrated (35). This indicates that health-promoting initiatives should target older persons aging in the context of migration at a younger age than their native-born

Swedes peers. Therefore, PAMC (18) targeted people aged ≥ 70 years. The concept of aging in the context of migration used in this thesis refers to people aged ≥ 70 years who have migrated to Sweden from Finland and the Western Balkan region at different ages and for different reasons.

1.2 Capabilities for optimal aging

This thesis builds upon the view that all humans are occupational beings and that all people are capable persons with the resources required to achieve what is considered good in life (42, 43). However, the capability to convert one's resources to achieve desired goals and to age optimally in one's environment may vary from person to person. Therefore, a capability approach is applied in order to determine each person's possibilities to age optimally. Capabilities is defined as the effective opportunity a person has to convert available resources into achievement of a valued goal (44). That is, capabilities refer to a person's freedom to choose to do and to be what they value and be able to act upon these wishes.

Different concepts exist that describe the desired experience of growing old and coping with common changes in life. In this thesis, one such concept is optimal aging (45), which is defined as the capacity to function across physical, functional, cognitive, emotional and spiritual life domains to one's satisfaction despite one's medical conditions. It implies that people seek to optimize their capabilities or satisfaction with life despite changed conditions such as becoming frail or experiencing a decline in health status due to aging (45). In contrast to the biomedical definitions of successful aging, which defines states as frailty, illness, and disability as non-successful (46), optimal aging accounts for each person's ability to adapt to new life situations by selecting certain activities that are most satisfying and meaningful based on personal conditions and the surrounding environment (45). This reasoning is in line with occupational therapy literature in which people are described as continuously adapting their occupations as a response to occupational challenges and models. Therefore, the ongoing interactions between the person, the environment and the chosen activity are considered to influence the performance of meaningful occupation (42, 47).

Occupation encompasses all activities and tasks in everyday life; that is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity) (42). Occupations are culturally situated and what people choose to do is influenced by various factors which influence the meaning given to occupation. Doing is linked to

words such as action, making, executing and performing and can be explained as mental, physical, social, communal, spiritual, restful, active, obligatory and self-chosen occupations (48). The occupations in which people engage may vary over their life course and between individuals. Aging may not only involve biological losses, leading to frailty, but also other significant changes such as shifts in roles and social positions and the need to deal with the loss of close relationships (2). Older people tend to optimize their abilities through practice and compensate for ability losses in new ways to accomplish tasks. They also tend to select fewer and more meaningful goals and activities (49). Both aging and migration processes might contribute to existing challenges, which may lead to a loss of meaningful occupation in everyday life. Such occupational losses may impact one's health negatively (42). Therefore, adapting occupations or adding new meaningful occupations for older persons aging in the context of migration might be required in order to experience health. According to the World Health Organization (50), health refers to a resource for everyday life that emphasizes both personal and social resources and physical capabilities, and not only the absence of disease. In this thesis, health is understood to be related to the ability to do what you want to do, to participate in activities, to realize ideas and values and to overcome the challenges one faces (51, 52). Thus, occupation is interrelated with health and can be viewed as both a means to achieve health and an appropriate health outcome owing to its significance to experiencing health (42, 53). Therefore, this thesis applies an occupational lens to understanding 'doings' as promoting health among health-care personnel for older people aging in the context of migration. At the individual level, occupations concern the outcome of activities of daily living (ADL). Here, we define ADL as doings intended for taking care of one's own body and supporting one's everyday life within the home and community (54).

The capabilities of older people aging in the context of migration to achieve valued health goals, (i.e, optimal aging), is shaped by the interplay between internal and external factors. Internal factors that influence a person's health capability are for example health status, health knowledge, and health-seeking skills (55). Factors are influenced by prerequisites in the county of birth as well as the country of residence. External factors related to one's environment include social norms, social networks, economic situation, and access to health-care services (55). The majority of previous research has mainly described factors that can diminish capabilities. Studies show that people aging in the context of migration might face both age-related decline in bodily functions (36) and migration-related challenges associated with environmental factors necessary to maintain health (11, 56). Psychosocial

and cultural changes associated with migration can be experienced as stressful events and may not only affect language problems that one may face, but also their life situation in the new country (56). In addition, older people born abroad are often confronted with poorer living conditions compared with native-born people (30, 57). Thus, the intersection of being an older person and having experienced migration might have a negative impact on the capabilities to age optimally by influencing determinants of health, such as socioeconomic status and the ability to be active. Older people aging in the context of migration are therefore considered an important target population for health-promoting interventions, because of exposure to both physical and social frailty.

1.3 Promoting health in a migration context

Health promotion is a strategy for improving public health. It has been defined as a process to enable individuals and communities to increase control over or improve their health (50). Health promotion in health services is a shared responsibility amongst individuals, community groups, health professionals, health-service institutions, and governments, and requires the involvement of different stakeholders (50). The concept of promoting health in a migration context might therefore include a variety of interventions with different goals directed towards both the individual person as well as the societal level and with the different stakeholders involved (50, 58, 59). In this thesis, health promotion refers to the administration of a health-promotion program aimed to enable older people to manage everyday life. Thus, the view of health promotion used in this thesis incorporates both actions performed during the program and actions taken by older people born abroad in their everyday life after their participation in the program.

Health-promotion programs are one possible strategy to enabling health in the aging population (60). Enablement refers to reducing differences in current health status and ensuring equal opportunities and resources to allow all people to achieve their fullest health potential (50). Previous studies reported barriers related to access to health services or health information among migrants (11, 26, 61). There are identified needs to adapt health promotion programs to bridge cultural and linguistic barriers to make these programs available to the targeted population (62, 63). A literature review and meta-analysis showed that cultural and linguistic modifications of activities and health information were conducted in health promotion programs for older people who represented a diverse range of cultural,

linguistic, ethnic or national backgrounds. It also highlighted a person-centered approach and professional provision as core components of health-promotion programs to support the targeted population in developing and maintaining healthy lifestyles during their life course (62).

1.3.1 The current evidence base

Health-promoting studies that include people with a migration background are scarce. The aforementioned meta-analysis and literature review (62) of health promotion for older culturally and linguistically diverse persons included eight publications that evaluated six different health-promotion programs. It provided evidence for health promotion in cases of depression, mental health, physical health, and vitality for programs with the above-mentioned core components. However, the quality of the evidence was low and the author called for further studies (62). Furthermore, to my knowledge, only a few studies have evaluated the outcome of ADL. Two studies (64, 65), conducted in a North American context, reported results concerning ADL, but neither showed significant findings. A few studies (66, 67) described health or health resource experiences in everyday life from the perspective of older persons born abroad. However, neither study described the experience of health-promotion programs.

Numerous studies and reviews (4-6, 19-21) exist that report on health-promoting interventions for older people. These show that health-promoting interventions are important in supporting older people in managing their everyday lives and how they experience health (4-6). Furthermore, health-promotion programs can delay functional decline and mortality (6), as well as reduce both falls and hospital admissions (5). A group-based health-promotion program 'senior meetings' (19), developed in the Swedish context have shown promising results among independent living persons aged ≥ 80 years. For example, the program was shown to positively affect maintenance of independence in daily activities at both 3-month and 1-year follow-ups (4, 20) and self-rated health for up to 1 year (21).

1.3.2 Health-promoting senior meetings

Senior meetings comprised four weekly group meetings and a follow-up home visit. A multidisciplinary team consisting of an occupational therapist, a physiotherapist, a registered nurse, and a qualified social worker administered the meetings. Health information was provided in a written booklet and discussed during the meetings. A person-centered approach was used, which emphasizes people's expertise regarding their own situations (68). In addition, peer learning (69) was used so that participants could learn

from each other. Thus, the content and design are multidimensional and includes core components such as professional provision, activity, health information and a person-centered approach described in the meta-analysis referred to previously (62). Due to these similarities, and the proven impact of senior meetings for older native-born Swedes, a hypothesis was developed: the program (with minor adaptation to content and design) could prevent or delay deterioration in health-related outcomes for pre-frail individuals aging in the context of migration. Therefore, the original 'senior meeting' protocol (19) served as an evidence base when implementing the program in a setting where a high proportion of people are born abroad, have a generally lower socioeconomic status and educational level compared with where the original program was developed.

1.4 From knowing to doing in partnership

An important strategy for achieving evidence-based practice is cooperation, which aims to strengthen researchers' relationships with practitioners and policy makers (70, 71). Furthermore, a person-centered approach was applied during the senior meeting. A person-centered approach is an ethical point of departure that guides professional actions with the aim to acknowledge the *person* in need of health services. It is as such founded on the view that all human beings are capable to achieve what they consider a good life (15, 43). In this thesis, a person-centered approach was applied to put emphasis on the involvement of older persons as active partners in the health promotion process, i.e. to recognize them as experts on their own situation (15, 68). Thus, the movement from knowing to doing in partnership that is central to this thesis refers to both the process of moving evidence to practice in a researcher-community partnership that can support clinical decision making, and to the process of promoting health based on shared decision-making between health-care personnel and senior meeting participants.

1.5 Moving evidence to practice

Moving evidence to practice refers to strategies used to support evidence-based practice. This means integrating the best available research evidence, professional expertise, and experiences and preferences of the target group into clinical decision-making (12). Evidence is a form of knowledge from various sources believed to be reliable. Research is part of evidence that can constitute application of knowledge in a given context (25). In relation to evidence-based practice, Metzler (17) described how occupational therapists'

and clients' knowledge is not secondary to research evidence but that any kind of knowledge is essential and complementary. This view is shared by other health professions, when defining the evidence in evidence-based practice (72-74). In this thesis, the concept of evidence therefore includes both research evidence, professional experience and experience of older persons born abroad, knowledge that will be translated into action. A researcher-community partnership was used as an implementation strategy to support the process of moving evidence to practice.

The concept "Knowledge translation" used in this thesis is one of many concepts that describe how the process of moving evidence to practice can be supported (70). A common definition of knowledge translation is the one used by the Canadian Institute of Health Research. They define knowledge translation as the exchange, synthesis, and ethically-sound application of knowledge within a complex system of interactions among researchers and users (such as policymakers, health-care personnel or the targeted population) to accelerate the capture of the benefits of research for the population through improved health, more effective services and products, and a strengthened health-care system (75). In this thesis, the framework Knowledge To Action (KTA) as described by Graham (70) is applied to understand how knowledge exchange between reference groups with older persons born abroad, health-care personnel and researchers may support the process of moving evidence to practice. The framework describes knowledge translation as comprising two interacting components: 1) knowledge creation, and 2) action. Knowledge is created through both research and experiences among knowledge users, such as experiences from clinical practice of preferences among clients, and reflects three generations of knowledge: inquiry, synthesis, and tools/products. An action cycle is implemented and includes eight activities needed for moving evidence into practice; problem identification, identifying appropriate knowledge, applying knowledge to the local context, assessing barriers to knowledge use, developing, tailoring and implementing interventions, monitoring the knowledge, evaluating the outcomes, and sustaining the knowledge use. This is a dynamic process; i.e., all phases can be influenced by one another and by the knowledge-creation process (70). This thesis covers both knowledge creation from inquiry to tools/products and the activities described in the action cycle except from sustainability. As a complement to the KTA framework, other frameworks such as the Promoting Action on Research Implementation in Health Services framework (74) and Consolidated Implementation Research Framework (76) have been applied. These frameworks contribute information on how contextual influences such as

partnership approaches, nuances regarding what could be adapted, and how the perception of evidence might influence implementation.

1.5.1 Adapting evidence to context

Adaptations are considered a natural part of implementation when moving researched-based evidence to practice. Improving the fit between the program and the local context is one clear motive for adaptations (70, 76). In this thesis, adaptations are defined as activities that customize or tailor original program content and design to current settings and circumstances (70). The settings and circumstances refer to the context in which the program is implemented and the everyday life of the older persons who participate in the 'senior meetings'.

Contextual influence on doings is crucial in both implementation science and occupational science. Implementation is described as a social process intertwined with the context in which it takes place (76). In implementation science, the contexts are often described in terms of internal or external contexts that can be linked to the outcome of the implementation. The inner context refers to conditions and characteristics of the health service organization or the setting where the implementation takes place, such as culture and available resources. The external context refers to social conditions such as laws, regulations, demographics, and social norms (1, 76, 77). In occupational science, the context is described in terms of environment. People and their environments are described as inseparable, and environments offer opportunities, resources, demands, and constraints (47). Townsend and Polatajok (42) describe environments as having been built up by physical and social factors that affect and are affected by human occupation. The physical environment refers to natural and built factors, whereas the social environment encompasses aspects of social interaction in daily life, social groups (i.e., families or workgroups), and social structures such as organizational and institutional policies and regulations. Culture is a feature of social environment, which can be understood as shared ideas, views, and knowledge within a group (42), including beliefs, values and norms that shape the patterns and rules of behavior that people live by in their everyday life (78). Culture is shaped by perceptions a person has of themselves and their environment, and forms under constant interaction with others (42), which makes culture a dynamic concept. The strategies older people use to achieve individual goals during the aging process may differ between different cultures and a person's views on independence in ADL or health (79). Of importance, experiences are unique and the same individual often belongs to different subcultures. Furthermore, culture encompasses much more than just ethnic origin or religious affiliation (80).

The above description shows that adaptations of health-promotion programs might be a result of both contextual influences on the implementation process and the interaction between person, environment, and occupation.

Findings of intervention research have reported on how health-promotion programs targeting older people born abroad are adapted according to population characteristics such as culture and language (62, 81). Studies (82, 83) with an implementation perspective report both advantages and disadvantages of program adaptations. A recent study (82) reported better outcomes for adapted programs compared with programs with high fidelity to the original protocol. The literature also recommends fidelity for core components; i.e., program content and design, which are central in achieving program outcomes (83). Thus, the degree to which an intervention can be tailored to meet local needs is dependent on what is considered to be ‘core components’ of the program versus the ‘adaptable periphery’ (adaptable elements, structures, and systems related to the intervention and organization into which it is being implemented). Identifying core components is often a trial and error process, which takes time (76). This can be considered to be the case for health promotion targeting older persons where the ‘black box’ of what makes a program work is often unknown and requires investigation.

1.6 Evaluating complex health-promotion programs

Complex health-promotion programs can be described as interventions that contain several interacting components. The degree of complexity could depend on different characteristics such as the number of interacting program components, the variability of outcomes, or the degree of flexibility of tailoring the intervention (84).

When designing of health-promotion programs targeting older people with migration experience, heterogeneity within the target group needs to be acknowledged (16, 27). Heterogeneity is related to the uniqueness of each individual, but also to personal prerequisites influencing health. For instance, health-related heterogeneity can entail an accumulation of factors across one’s life course, health behaviors, being a smoker, frequency of exercise, and diet. This requires not only a multidisciplinary perspective but also a person-centered approach (16); by which all decisions related to the health-promoting intervention are made in partnerships between the targeted person and the intervention provider (15). This makes Promoting Aging Migrants’ Capabilities (18) a complex program with several interacting program components and a range of possible program outcomes (84). Such programs are challenging to evaluate (85), and it is important to evaluate the

results of complex programs as well as the process leading to these outcomes. Therefore, randomized controlled trials should be complemented with process evaluations to understand the positive and negative results in the evaluation (84). Thus, to improve our understanding of program outcomes and support future program development, the studies in this thesis contribute different perspectives for evaluating the Promoting Aging Migrants' Capabilities program.

2 RATIONALE

Two major population changes contribute to the rationale for this thesis: global migration, and an aging population. Global migration is today an international issue affecting all countries globally (86). In addition, the world's population aged ≥ 60 years will increase rapidly. The year 2050 will see 2 billion people aged ≥ 60 years compared with 600 million in the year 2000 (87). Thus, both the individual person and society may benefit of evidence based health services to support optimal aging in the context of migration.

Health and occupation can be considered a human right (88, 89). Health-promoting actions should reduce differences in current health status and ensure equal opportunity and equal access to resources to enable all people to achieve their fullest health potential (50). The Swedish National Board of Health and Welfare (90) emphasizes that health and care services should provide equal services for the entire Swedish population and that services should be person-centered and based on best available evidence. However, there is an identified need to support the use of research evidence when providing health-promoting interventions targeting older persons in Sweden (91). Furthermore, the amount of research evidence for such interventions varies between different areas and among targeted populations. Less evidence is produced in the public health sector than the medical sector (14). In addition, being old or not speaking the majority language has been shown to lead to underrepresentation in research studies (13, 92). Thus, opportunities for people aging in the context of migration to access evidence-based health services are affected.

To my knowledge, there are no studies evaluating a person-centered, group-based health promotion program aimed at supporting optimal aging in the context of migration. Studies are also lacking in the exploration of how the content and design of these programs promote health, and the ability of older people aging in the context of migration to apply messages from health-promotion programs to everyday life. Thus, knowledge needs to be developed regarding how to facilitate implementation of evidence-based health promotion of value for older people aging in the context of migration, and to evaluate the outcomes of such programs.

3 AIMS

The overall aim of this thesis was to explore how to support the development and realizing of an adapted health-promotion program, its benefits, and impact for older persons aging in the context of migration. The specific aims were:

- To explore if, when, why, and how content and design of a health-promotion program was adapted in a researcher-community partnership during its implementation.
- To explore the experiences of the implemented content and design of Promoting Aging Migrants' Capabilities among persons aging in the context of migration.
- To explore the experiences of applying health-promoting messages amongst older persons born abroad 6 months to 1 year after their participation in Promoting Aging Migrants' Capabilities.
- To evaluate the 6-month and 1-year effects of Promoting Aging Migrants' Capabilities with a focus on independence in daily activities and on self-rated health.

4 PARTICIPANTS AND METHODS

4.1 Overall study design

In this thesis, a combination of qualitative and quantitative research methods was used to address the overall aim. The specific research questions guided the choice of methods and their epistemological ground. Qualitative approaches in form of one case study (study I) and two grounded theory studies (studies II–III) were conducted to develop deeper understanding of how program development and implementation influenced program outcomes. In order to evaluate the impact of the program, an randomized controlled trial (RCT) (study IV) was conducted. Thus, qualitative and quantitative research methods complemented each other by their contribution of different forms of evidence to program evaluation. An overview of methodological approaches is presented in table 1.

Table 1. Overview of methodological approaches, samples, and time point for data collection.

	Study I	Study II	Study III	Study IV
Design	Explorative	Interpretive	Interpretive	Experimental
	Qualitative case study	Grounded theory	Grounded theory	Randomized controlled trial
Sample/Data material	12 people: representing the steering committee, operative group, and research group Documents	14 people aged 70–84 years who have participated in the PAMC	12 people aged 70–84 years who have participated in the PAMC	131 persons aged ≥ 70 years who migrated to Sweden from Finland or the Western Balkan region
Data collection	Focus groups Individual interviews Documents review	Individual interviews	Individual interviews	Face-to-face interviews according to a study questionnaire
Time point for data collection	2011–2015	2012–2015	2013–2015	2012–2016
Data Analysis	Pattern matching Content analysis Focus group analysis	Grounded theory inspired by Charmaz	Grounded theory inspired by Charmaz	Chi-square Odds-ratio

4.1.1 Methodological choices and assumptions

Case study

Case studies are preferable when studying current events, which cannot be controlled or separated from the context in which they occur (93). Study design differs depending on the case to be studied, which can exist in different forms. Common to single-case studies is that they rely on multiple data sources (94). Study I conducted an explorative single-case study, which was inspired by Yin's methodology (93). This was considered to be a suitable method because it enabled the exploration of the process of adapting the original program (19) to PAMC (18) in the context of moving evidence to practice in a researcher-community partnership. A single-case design was justified because the aim was to study a unique case with a longitudinal perspective (93).

Grounded theory

A grounded theory (GT) design was chosen as a suitable method for studying processes and action (95). Grounded theory was developed by Glaser and Strauss in 1967 but is currently represented by three directions; the classic GT, the reformulated GT, and the constructivist GT (96). The common goal for these directions is to develop useful theory that is grounded in data (97). In studies II–III, the sampling and analysis were inspired by the constructivist grounded theory approach described by Charmaz (95). Central to the constructivist GT is the understanding that people including researchers construct their realities, and the goal is to gain situational knowledge rather than creating general abstract theories (95). A constructivist approach is suitable for addressing the “processes of interaction” among people and to deepen the understanding of the specific contexts in which people live and work in order to understand the historical and cultural settings of the participants (98). Therefore, the constructivist GT was considered suitable for gaining a deeper understanding of the realizing of health-promoting processes during the senior meetings (study I) and the continuation of these processes in everyday life (study III).

Randomized controlled trial

An RCT was considered a suitable choice because the goal was to evaluate the effect of senior meetings on ADL and self-rated health. RCTs are considered the gold standard for testing the efficacy of health interventions, and research indicates that they provide the best possible quantitative evidence of efficacy and effectiveness (99).

4.2 Study setting

Studies I–III within this thesis were conducted in a suburban district of a medium-sized Swedish city (suburban area 1), whereas study IV also included participants from a district with similar demographics (suburban area 2) as well as the medium-sized city. Suburban area 1 is a multicultural district and the inhabitants come from over 100 different countries. Among people aged ≥ 65 years, countries in the Western Balkans and Finland are the dominant countries of birth. For detailed information on the demographics of the study setting compared with the medium-sized city and Sweden see table 2 (100, 101).

Table 2. Overview of the demographics of the study settings.

Demographics	Suburban area 1	Suburban area 2	Medium-sized city	Sweden
Total population 2015	51 214	48 274	548 190	9 851 017
Born abroad	51%	42%	23%	16%
Aged ≥ 65 years	11%	12%	15%	20%
General education level¹	10%	11%	24%	28%
General income level² (Swedish krona)	176 700	180 600	243 400	228 400

¹University ≥ 3 years among people aged 65–74 years

²For people aged ≥ 65 years

4.2.1 Promoting Aging Migrants' Capabilities study

Promoting Aging Migrants' Capabilities (PAMC) (18) aimed to implement and evaluate health-promoting senior meetings with a person-centered approach. The program targeted independent living from two of the largest immigrant groups among older people aged ≥ 70 in the study setting persons who had migrated to Sweden from Finland or the Western Balkan region. The evaluation and implementation were performed in a researcher-community partnership, comprising health-care personnel (the operative group), research team members and a project steering committee. The partner's role during implementation and evaluation was stated in a cooperation agreement. The operative group was responsible for recruiting participants and conducting the intervention. The research group was in turn responsible for study design and conduct, whereas the steering committee was responsible for final protocol approval and reviewing any necessary changes to the original protocol (18, 102). Besides reference groups with

older people born in Finland or the Western Balkan region and persons participating in the senior meetings were involved in dialogues in program development, implementation and execution of PAMC.

Content and design of the original protocol

Intervention group

The health-promotion program, i.e., the senior meetings, consisted of four weekly small-group sessions (4–6 participants) followed by an individual home visit. The group sessions were based on a booklet especially designed for the target group and developed with target group representatives (19). The senior meetings were designed to provide an arena for peer learning (69), and included health information exchanges with an interprofessional team. The team consisted of a physiotherapist, a registered nurse, an occupational therapist, and a social worker. Team professionals were responsible for one session each, and one professional (the group leader) was designated to follow the group throughout the program to provide continuity (19). A person-centered approach (68) was implemented by addressing health-promoting actions based on the participants' own life experiences. This approach is founded on the view that all human beings are capable persons and emphasizes the involvement of participating persons as active partners who are experts in their own situation (15, 68). Shared decision making was applied, meaning that all decisions concerning health-promoting activities ought to be taken in partnership between participating persons and the interprofessional team (15). Thus, both participants and personnel brought their expertise into the senior meetings.

Control group

The participants allocated to the control group received no intervention. However, they could, on their own initiative, approach the ordinary range of community or health services (e.g., home help services, rehabilitation, or medical care) whenever they felt they needed them. If need for community or health-care services was identified at baseline or at follow-ups, information was provided on where to receive help.

4.3 Recruitment and participants

4.3.1 Health-care personnel, steering committee members and researchers (study I)

Twelve participants were purposefully sampled due to their role during program implementation because our intent was to explore different perspectives of adaptations. Participant inclusion criteria were conducting program adaptations or being involved in decisions regarding program adaptations. In total, 11 people were recruited for focus group discussions and nine people for individual interviews. Eight people participated in both focus group discussions and individual interviews. One person declined participation in the individual interview.

Participants' characteristics (study I)

To ensure homogeneity in each focus group, one group comprised personnel working in the field (n=5) and the other research team members (n=6). Heterogeneity was also sought to ensure variance and to broaden discussions (103). To ensure heterogeneity, the recruited participants represented different professions, genders, degrees of education, and roles in implementation. Focus group 1 consisted of three senior researchers, two junior researchers and one PhD student, representing two professions. Focus group 2 represented four professions. Both groups included male and female participants, but the majority of the participants were female. Individual interviews included seven women and two men. Professions represented included occupational therapists, physiotherapists, registered nurses, social workers and physicians. They also represented different perspectives of the partnership, belonging to the operative group, research team, and the steering committee.

4.3.2 People aged ≥ 70 years who migrated from Finland or the Western Balkan region (studies II–IV)

Because the recruitment of participants in studies II–III were drawn from the sample in study IV, the inclusion criteria for participation in the PAMC study (IV) will be presented first. Thereafter, the recruitment procedure for studies II–III will be detailed.

Enrollment in the randomized controlled trial (study IV)

To be included in the PAMC study, the following inclusion criteria should be fulfilled: (a) migrated to Sweden from Finland or the Western Balkan region, (b) aged ≥ 70 years, and (c) community-dwelling and independent of help of another person in ADL, as measured by the ADL-staircase (104, 105). Impaired cognition was considered as exclusion criterion due to ethical reasons. People who scored $< 80\%$ accuracy of administrated items on the Mini–Mental State Examination (106) at baseline were therefore excluded.

Trained research assistants or personnel in the operative group conducted the enrollment and baseline assessment in the participants' preferred language. Enrollment of participants took place in three recruitment waves to reach the intended inclusion rate. In the first and second waves, eligible participants were drawn from official registers in two selected suburban districts (suburban area 1 and 2) of a medium-sized Swedish city. Letters were posted, followed by a telephone call approximately 1–2 weeks later. If a telephone number was unavailable, a second letter was sent with a request for a response. In the third wave, snowball sampling (107) was used. This involved former participants or key persons in reference groups disseminating information about the study to older persons (the researcher-community partnership), and by advertising on a local radio station. Those interested in participating were asked to contact the researchers for more information. Eligibility assessment was performed for people ($n=749$) with whom contact was established by telephone or who sent a reply by post. In total, 131 people fulfilled the inclusion criteria and consented to participate. They were allocated to the intervention group ($n=56$) or the control group ($n=75$). The majority of allocated participants were recruited in the first wave ($n=88$). In the second and third waves, the recruitment included 37 and 6 participants, respectively (Figure 1).

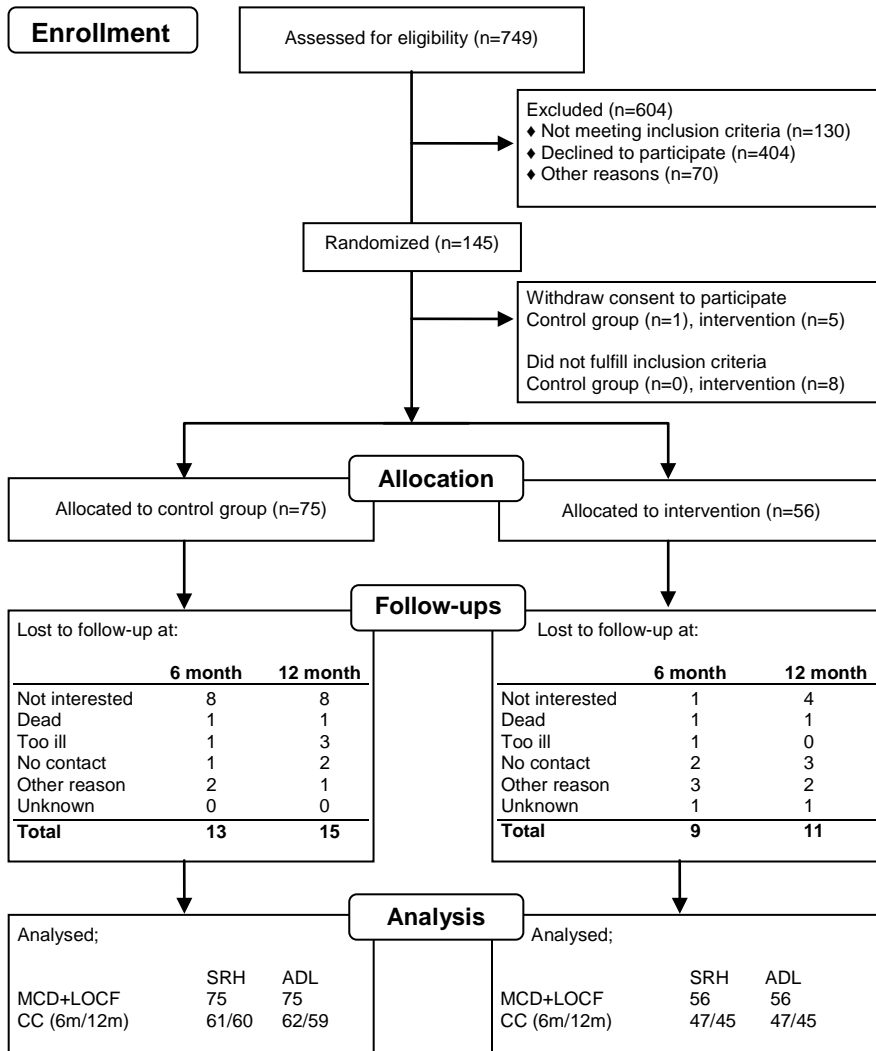


Figure 1. The flow of participants through Promoting Aging Migrants' capabilities study and the reasons for declining participation at the 6-month and 1-year follow-ups.

Abbreviations: SRH, Self-Rated Health; ADL, Activities of daily living, MCD, median change deterioration; LOCF, last observation carried

Enrollment in grounded theory (studies II–III)

Participants in studies II–III were, in line with Charmaz (95), selected due to initial sampling criteria among participants who were allocated to the intervention group. The initial sampling criteria were set up to reach heterogeneity in age, gender, type of housing, language spoken during senior meetings, and marital status. Later, theoretical sampling was also used. The enrollment continued until theoretical saturation was reached. This meant that no new properties of the categories emerged during data collection (95). In study II, 14 participants were included, and were subsequently requested to participate in study III. Two women declined further participation. Because interview numbers eleven and twelve in study III did not contribute to new properties, the categories were considered to be saturated (95). Therefore, 12 participants were included.

Participants' characteristics (studies II–IV)

An overview of demographics for people participating in studies II–III and study IV is provided in table 3. It shows similar trends for demographic data.

Table 3. Characteristics of enrolled participants in studies II–IV.

	Studies II–III¹ n=14	Study IV n=131
Age, range (years)	70–83	70–84
Sex, male n (%)	6 (43)	66 (50)
Living alone, n (%)	6 (43)	63 (48)
Type of housing, n (%)		
Tenant	6 (43)	68 (52)
Owner of house or apartment	8 (57)	61 (47)
Other	0 (0)	2 (1,5)
Education, n (%)		
Tertiary education	3 (21)	20 (16)
Low education	4 (29)	28 (22)
Migrated from, n (%)		
Western Balkan region	5 (36)	60 (46)
Finland	9 (64)	71 (54)
Years lived in Sweden ≥21, n (%)	13 (93)	114 (87)
Reasons for migration, n (%)		
Labor	8 (57)	47 (37)
Refugee	3 (21,5)	26 (20)
Family	3 (21,5)	16 (13)
Other	0 (0)	38 (30)
Good self-rated overall ability to speak Swedish, n (%)	12 (86)	117 (89)
Good self-rated overall ability to speak Swedish when contacting authorities, n (%)	12 (86)	103 (79)

¹To protect the identity of the participants who dropped out in study III, studies II and III are presented together.

4.4 Data collection

A variety of data collection methods were applied to address the aims of the different studies: focus group discussions, individual interviews, document review, and face-to-face interviews according to a study questionnaire. In the case study (study I), a variety of data collection methods were used because they were included in the study design to achieve credible results (93). Studies II–IV are based on one data collection method. The data sources used in each study are provided in table 1.

4.4.1 Focus group discussions (study I)

The goal of the focus group discussions was to gain a collective understanding of the case, as a starting point for further data collection. Two focus group discussions were held to give participants opportunities to stimulate each other in discussions to explore new issues that arise (108). Participants learn from each other through group discussions, and a collective understanding of the world is constructed through interaction (103). Each focus group lasted for 1.5 hours and was moderated by the first author, who also took field notes regarding the participants' interactions. The discussions were recorded and transcribed verbatim by the first author. The third author listened to the discussions and read the interviews to verify the transcriptions. A topic guide developed by the authors was used. It consisted of five questions, which were based on previous literature; 1) How would you describe what is central in the content and design of senior meetings? 2) How are you reasoning about the need to adapt the program to the context in which implementation occurs? 3) How would you describe the main adaptations during implementation? 4) Have you actively worked to encourage and/or inhibit adaptations? If so, can you explain how? 5) How do you view the role of each research-community partner in program adaptations?

4.4.2 Individual interviews (studies I–III)

Individual interviews allow in-depth exploration of a particular topic (95). Interview guides with question areas were used in all studies to facilitate interviewing (I–III). See table 4 for further details. Interviews were conducted differently for study I compared with studies II–III. In study I, the question areas remained the same for all interviews, whereas the question guides in studies II–III were complemented with new question areas according to the ongoing analysis as a response to theoretical sampling described in GT (95, 109). This required narrowing the range of topics to gather specific data for developing theoretical frameworks as interviews

proceeded (95). This is one explanation for the wide range of interview times in the GT studies compared with the case study interviews (Table 4). The way in which probes were used during the interview also differed. Probes such as “*Can you tell me more about that?*” were used in all interviews (study I–III). In studies II–III, probes were also formulated in line with intermediated questions suggested by Charmaz (95) to capture processes.

Interviews conducted in Swedish were performed by the first author (studies I–III), whereas interviews in the participants’ mother tongues (studies II–III) were conducted by research assistants who were university educated and fluent in both Swedish and the required language. The interviews were tape-recorded and transcribed verbatim in Swedish by the first author or in the mother tongue by research assistants, who then also translated the interviews into Swedish.

Table 4. An overview of how data were collected through individual interviews in studies I–III.

	Study I	Study II	Study III
Number of interviews	9	14	12
Time (range min)	53–88 (median 69)	18–167 (median 77)	22–125 (median 54)
Location	The participant’s workplace	The participant’s home	
Performed in Swedish	9	9	7
Performed in mother tongue	-	5	5
Question guide	Seven open-ended questions	One starting question	One starting question
Question areas	Probes	Probes	Probes
	-Reasons for adaptations or nonadaptations -Experiences working in a partnership -Experiences of adaptations in relation to program core components -Experiences performing adaptations during the implementation	-The booklet -Four group meetings -Follow-up home visit -Group discussions -Personnel and interpreter -Person-centeredness -Time and design	Usefulness or non-usefulness -Relevance or non-relevance -Opportunities or obstacles -Remembering or forgetting -Changing or not changing -Context -Individual and societal-level prerequisites -From thinking to doing or not-doing

4.4.3 Document review (study I)

Archive material and documents, such as protocols and process notes, covering the time span 2011–2014 were identified with help from the project leader in the operative group. For study inclusion, documents should describe when, why or how adaptations of the original program protocol were performed. In total, 13 documents were included.

4.4.4 The study questionnaire (study IV)

Data were collected from 2012 to 2016. Assessments were conducted in the participants' own homes or at another venue according to the participant's wishes. Trained research assistants conducted data collection in the participant's preferred language. The personnel in the operative group or the research assistants performed baseline assessments. Research assistants performed the follow-up assessments. To blind those assessing the outcomes for group assignment, for the majority of participants, different parties conducted baseline assessments and follow-ups.

Measuring the primary outcome: Activities of daily living

Independence from, or dependence on, another person in daily activities was assessed according to the ADL-staircase (104, 105), based in interviews with participants. The instrument applies a cumulative scale of well-defined personal and instrumental activities. Nine of 10 original activities in the ADL-staircase were used: cleaning, shopping, transportation, cooking, bathing, dressing, going to the toilet, transfer, and feeding. Dependence was defined as receiving personal or directive assistance from another person. Participants living with another person were assessed as "independent" if they were capable of performing the activity independently.

Measuring the secondary outcome: Self-rated health

The secondary outcome, self-rated health, was measured by the first question in the 36-Item Short Form Survey (SF-36) (110). The participants choose one of the following responses to the question "*In general, you would say your health is...*"; (1) excellent, (2) very good, (3) good, (4) fair, or (5) bad. The changes between baseline and follow-up were dichotomized into either decreased or maintained/improved.

4.5 Data analysis

4.5.1 Case study analysis: A two-step approach

A case description was built through an iterative analysis performed in two steps. The first step analyzed focus groups according to Kreuger and Casey (111) and the individual interviews using content analysis (112). Both the content analysis and focus group analysis started with listening to the recordings and reading the transcriptions to develop a sense of the whole material. Notes were written in the margin of immediate expressions. Next, meaning units were marked when using content analysis, which were condensed and thereafter given a label according to its latent content (112). In the focus groups analysis, the next step identified preliminary themes representing the essence of the whole material. Raw data (i.e., discussions) were marked and sorted into the preliminary themes according to an iterative process, and field notes were also used. Thereafter, thematic descriptions were written using raw data with the same essence (111).

In the second step, an overarching integrating analysis was performed by pattern matching. Different data sources and perspectives were triangulated to an overall case description by converging data (93). Triangulation was also used to identify divergence of perspectives into the case description (113, 114). Theme descriptions from the focus group analysis and codes identified in the content analysis were synthesized and sorted into categories or subcategories. Archive material, documents, and protocols were used to triangulate data in the categories.

4.5.2 A constructivist approach to Grounded Theory

Data analysis was guided by Charmaz (95) and was conducted in parallel with data collection. Initial and focused coding was used. In the initial coding, each line was coded close to the data. Later segments of data were synthesized and explained using a conceptual code (focused coding). These conceptual codes were compared and sorted into categories. Memos were used throughout the analysis process to record what was happening in data and to systematically compare codes and describe how categories emerged (95). Because interviews were performed in three different languages, research assistants who fulfilled the criteria for translating in a research context (115) were involved in data collection and analysis. They verified the essence of the initial and focused coding performed by the first author, wrote memos after each interview, and participated in the discussions during the analysis.

4.5.3 Statistical analysis

In study IV, both descriptive and analytical statistics were used to compare groups and for analyzing change over time. The proportion of participants who had maintained independence in daily activities according to the ADL-staircase (104, 105), or maintained or improved self-rated health (110), was calculated during the course of the study. In line with the hypothesis, the participants were dichotomized into maintained/improved or non-maintained from baseline to respective follow-ups in the final analysis. An overall chi-squared test was performed, then between-group comparison was made by calculating the odds ratio (OR). The confidence interval (CI) is provided, using normal approximation of the log-odds ratio. All statistical tests were two-sided, with $p \leq 0.05$ considered statistically significant. Data were analyzed using SPSS version 22 (IBM Corp., Armonk, NY, 2009).

Analyses were performed based on the intention-to-treat principle, which meant that all participants were analyzed in the group to which they were randomized (116). To present as nuanced and comprehensive results as possible, analyses were conducted by using two different imputation methods for those lost to follow-up; median change deterioration (MCD) (117) and last observation carried forward (LOCF) (118). In addition, a complete case analysis (CC) was performed, serving as a sensitivity analysis. For MCD as an imputation method, two assumptions were made: older people are expected to deteriorate in health over time due to the aging process, and deteriorated health is a common reason for not completing the follow-ups (119). Thus, missing values were replaced with a value based on the median change of deterioration between baseline and follow-ups. In contrast, for LOCF, it was assumed that the average unobserved outcomes within each randomized group do not change over time (118), meaning that health and independence were considered to be maintained. Using this approach, missing values at follow-ups were replaced with the last known observed value either from baseline or 6-month follow-up. Values for worst-case change were imputed for people who died before follow-up.

5 ETHICAL CONSIDERATIONS

The studies were approved by the Regional Ethical Review Board (821-11 and T947-12). Several ethical issues related to language should be considered as relevant as this thesis included people with limited Swedish language skills. Language barriers are a common reason why people aging in the context of migration often are excluded from research projects. This can result in unequal health care. To ensure that participants were aware of what it meant to participate in research, the invitation letter was provided in two languages (Swedish and the participant's native language). There were also possibilities to asking questions and obtaining verbal information in the preferred language before deciding if to participate. This aimed to safeguard the free informed consent. Translation of information and the study questionnaire, into different languages also enabled the participants to choose what language to use when interacting with the researcher or project assistants. Interpretation services were offered and used when desired by the participants. The mentioned strategies aimed to ensure that information was understood, and to protect the right to obtain health information.

This thesis aimed to evaluate and obtain knowledge of health-promoting interventions for persons aging in the context of migration, which may contribute to better health. The PAMC project targeted initially people aged ≥ 70 years born in Finland, or the Western Balkan region because these are the largest immigrant groups among older people in the study setting. There is always risk of stigmatization when interventions are directed to specific populations according to nationality because being Swedish-born may be seen as the norm. This must be weighed against the possible benefits of the research project. The project may gain knowledge about how to administer health-promotion interventions among older persons aging in the context of migration, which in turn can lead to greater health-care equality. It was also a strategic choice to test and evaluate the intervention at a small scale before deciding whether it should be permanent. However, the goal was to develop an inclusive approach which in the long run will be provided to older people in the studied area (including persons in the control group) if benefits or effect of the intervention is shown.

Ethical considerations were also made to be prepared to address emotional reactions or other questions that could be evoked during the intervention or individual interviews. The group leader or interviewer planned for and arranged extra time if this was the case. If a need for further professional contact were required, the participants were referred to usual health- or elderly care.

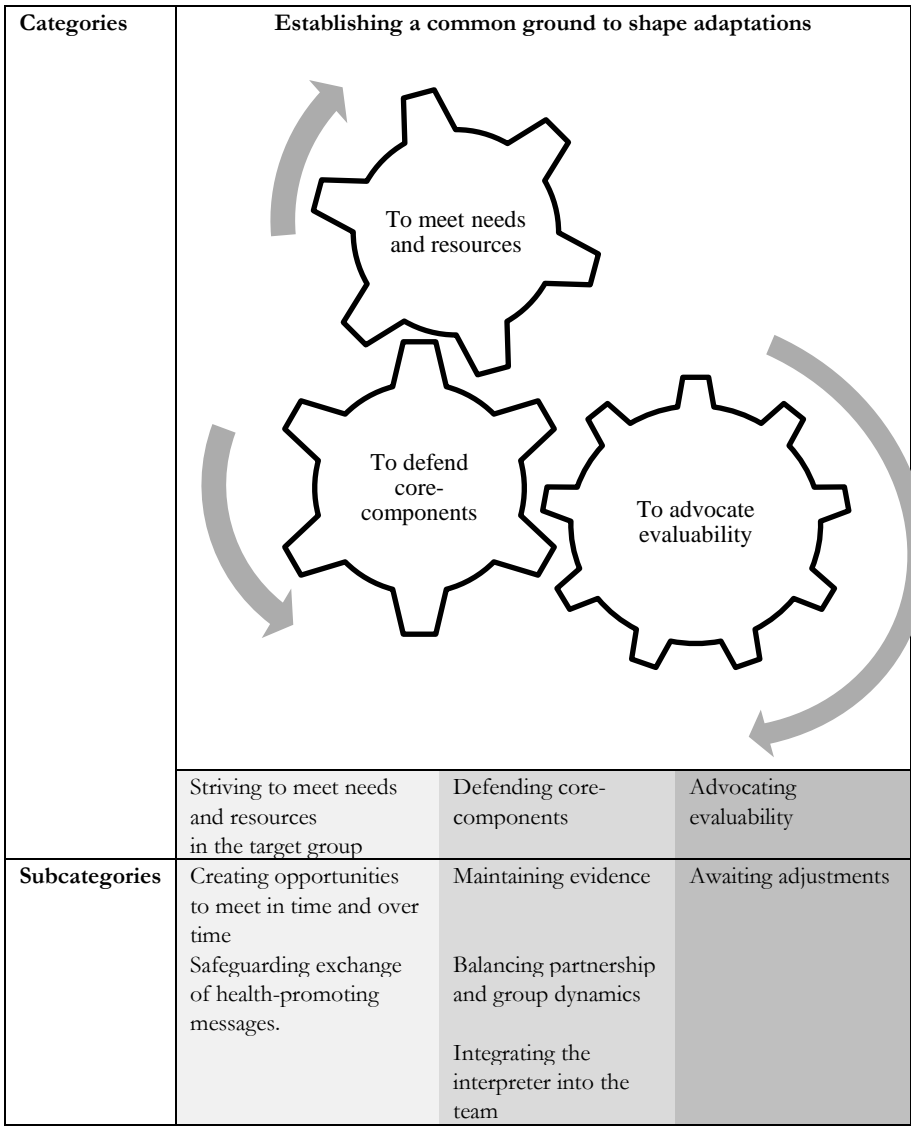


Figure 2. An overview of categories and subcategories explaining the course of events that underpin the dynamic process; negotiating toward suitable solutions.

6 RESULTS

Here, the contribution of each study to the whole will be presented, followed by a summary of the main findings. See the appendix for more detailed results of studies I–IV.

6.1 Negotiations as a way to support suitable program adaptations

Study I contributed results regarding how knowledge was translated into action in a researcher-community partnership. Thus, results were reported on conducted adaptations compared with the original protocol. The results describe the adapted program content and design, which is further explored and evaluated in the other studies (II, III, IV).

A dynamic process *negotiating toward suitable solutions* were identified to explain if, when, why, and how adaptations were performed to be considered to work and be acceptable from different partners' perspectives (Figure 2). How the researcher-community partners could bring their own perspectives and competence into the negotiations varied over time and depended on the prerequisites created for negotiation (establishing a common ground to shape adaptations). The prerequisites of being able to shape adaptations ranged from being in two separate 'worlds' where a lack of understanding and a power imbalance were experienced, to experiencing conditions of being able to shape adaptations jointly.

6.1.1 Reasons driving the negotiation process

The negotiation process was underpinned by a course of events taken to support or inhibit adaptations driven by the interplay within and between three reasons; to meet needs and resources in the target group, to defend core components, and to advocate evaluability. This interplay can be understood as a negotiation process toward suitable solutions explained by the categories striving to meet needs and resources in the target group, defending core components and advocating evaluability.

6.1.2 Actions to inhibit or support adaptations

The negotiation resulted in actions taken to adapt or not adapt the program content and design (presented as subcategories). Reasons for adaptation for each subcategory are provided in figure 2. For specific details of conducted adaptations, see table 5.

During negotiations, partners were *striving to meet the needs and resources* of the target group. This strive was met by adaptations to meet before the onset of dependence in ADL, and to establish sustainable relationships with health services even after the program (*creating opportunities to meet in time and over time*). Furthermore, adaptations were conducted in relation to linguistic, health-related and educational needs and resources among the targeted group with the intent to protect the rights of receiving, understanding, and being able to communicate health information (*safeguarding exchange of health-promoting messages*). By *defending core components* during negotiations, implementation of program content and design were supported. This inhibited adaptations by *maintaining evidence* from the original protocol. It also led to adaptations aimed at facilitating and enabling the implementation of program core components such as a person-centered approach and peer-learning. Adaptations were performed to achieve a power balance during the group sessions (*balancing partnerships and group dynamics*), and by creating space for and developing the role of the interpreter in group processes (*integrating the interpreter in the team*). By advocating evaluability during the negotiation adaptations, which were considered suitable solutions, could be postponed if they were considered to be a threat to the ability to conduct research (*awaiting adjustments*). One such example was identified solutions to better meet the target group by outreach visits to clubs and associations for seniors and immigrants.

Table 5. Overview of adaptations conducted during implementation. The adaptations are presented in relation to core components of the original program.

Original definition of core components	Adaptation of content and design	Comment;
Consists of 4 group-meetings followed by an individual homevisit	<ul style="list-style-type: none"> -Held "Senior Meetings" at times when local transportation services is free of charge -Held the meetings in different locations nearby the population -Offered individual follow-up visits outside the home if requested 	<ul style="list-style-type: none"> -Adaptations were preformed to be able to implement -A need for further development of outreach efforts was identified
Target pre frail persons 80 years or older independent of help	<ul style="list-style-type: none"> -Lowered the age to 70 years or older for inclusion 	
An interprofessional team consisting of RN, SW, OT and PT held the meetings	<ul style="list-style-type: none"> -Offered translation services -Developed team-roles to better balance power -Integrated an interpreter in the team when needed 	Adaptations were preformed to be able to implement
Health information is provided in a written booklet and in oral during the meetings	<ul style="list-style-type: none"> -Updated information to context -Added free of charge options to health promotion -Added health information concerning stress and psychological health -Translated written material -Performed language simplifications -Applied an bilingual approach -Offered bilingual audio-files 	Operative group compromised about language simplifications
The booklet is provided in advance and serves as a basis for group discussions	No	-
The meetings are based on participating persons needs and interests	<ul style="list-style-type: none"> -Clarified the personcentred-approach 	-
Peer-learning The participants share experiences	<ul style="list-style-type: none"> -Developed the role of the group leader -Applied new guidelines for group size when interpreter was included in the team -Used simultaneous interpretation -Offered choices of how to use translation services 	Adaptations were preformed to be able to implement
One professional follows the group through all meetings to provide safety and continuity	No	-

Abbreviations: RN, registered nurse; SW, social worker; OT, occupational therapist; PT, physiotherapist

6.2 Ways to raise awareness during the program

The results in study II showed how program content and design adapted in the researcher-community partnership (study I) contributed to raising awareness of how to promote health from a participant's perspective.

Older people experienced that the implemented content and design in 'senior meetings', promoted health by raising awareness about historical life events and strategies used, the current situation, and possible future scenarios (Figure 3). This was described in the core category; *Opening doors to awareness of the past, present and later life*. The analysis showed that participants and personnel jointly helped raise awareness according to their different roles and expertise. Three health-promoting processes were identified as opening doors to awareness during the program. The process of *providing opportunities to understand and be understood*, we learned that multidimensional, bilingual content, and the ability to choose how to learn, what to learn, and by whom, bridged barriers to health promotion. This process also informed us that health information was also searched by people such as neighbors and relatives on the behalf of others. In addition, being able to practice Swedish language skills to improve future understanding was described to be of value. The process *confirming human values and abilities* showed that the study content and design supported the experience of being recognized as a capable person regardless of age or origin. The ability to make one's voice heard, and recognizing, seeing, and listening to each other during the senior meetings contributed to this experience. The process *enabling community* was not related to gaining awareness about the aging process, but revealed the importance of seeing and socializing with peers or personnel as a means for participation.

Participants, personnel, and the interpreter, (referred to as the group in the article), shaped the contextual prerequisites for implementing health-promoting messages and actions by stimulating or inhibiting each of the three processes; thereby opening doors to awareness (*being shaped by the group*).

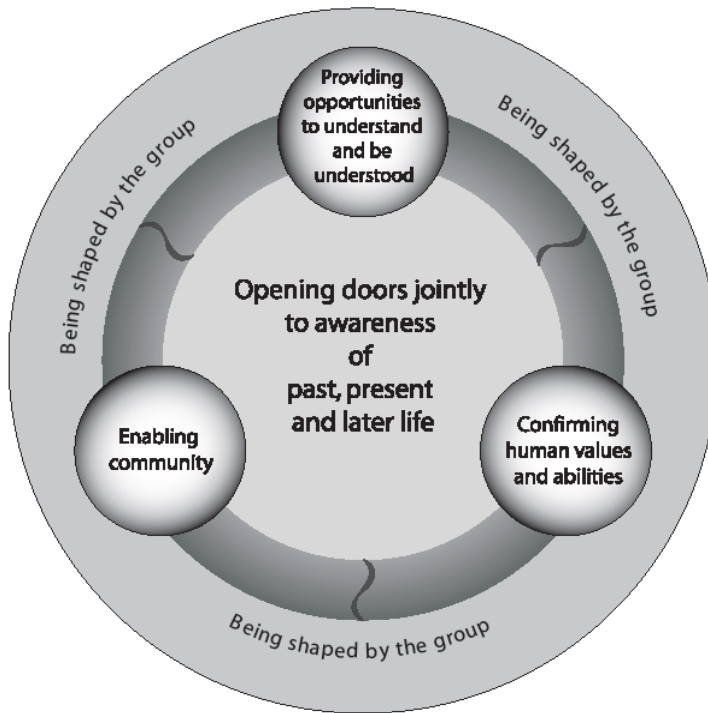


Figure 3. Model visualizing the understanding of the “black box” of a health promotion program from the perspective of persons aging in the context of migration¹.

¹ Originally published in Barenfeld E, Gustafsson S, Wallin L, Dahlin-Ivanoff S. Understanding the “black box” of a health-promotion program: Keys to enable health among older persons aging in the context of migration. *International Journal of Qualitative Studies on Health and Well-Being*. 2015;10:29013.

6.3 Integration of health-promoting messages in everyday life

The results of study III create a link between the three identified ways to raise awareness found in study II and the implementation and continuation of these in the participants' everyday lives. This contributed to the understanding of program outcomes by showing how health-promoting messages exchanged in PAMC were used as tools to support decision-making in everyday life. More specifically, the program supported decision-making about taking action now or deferring action to satisfy health needs for both oneself and for others (Figure 4).

Study III showed that health-promoting messages exchanged during PAMC were used as a power source in everyday life, experienced as *gaining inner strength*, expressed as feelings of serenity or a driving force to act. This in turn empowered participants to make decisions of either taking action 'now' or deferring action. The inner strength influenced three decision-making processes. Through one of the processes *being attentive to what is worth knowing*, we learned that health-promoting messages from the program directed the participants' attention to information of importance in order to approach health risks or advocate for others. What was considered worth knowing varied over time and influenced actions taken to gain more knowledge. Decisions were also made regarding taking action or deferring action in relation to the process *approaching health risks*. This included deciding whether one needs to act to avoid factors that are considered a threat to one's health, for instance by jeopardizing the ability to manage everyday life. Furthermore, participants decided whether to take or defer action to satisfy their health needs by *identifying opportunities to advocate for others*. Thus, the health-promoting messages from PAMC were also used to help family, friends, neighbors, or relatives. In sum, this shows that the information searched for during the program (study II) were used to satisfy health needs of both oneself and others in everyday life when making decisions about acting 'now' or deferring action to promote health.

Furthermore, the results in study III showed that the ability to act upon valuable messages could be facilitated or hindered depending on available personal and environmental resources. The experienced conditions for using health-promoting messages in everyday life varied over time and were influenced by both inspiring and obstructing challenges on personal and societal levels. This influenced participants' abilities to act upon valuable messages and was experienced as *meeting challenges in available resources*.

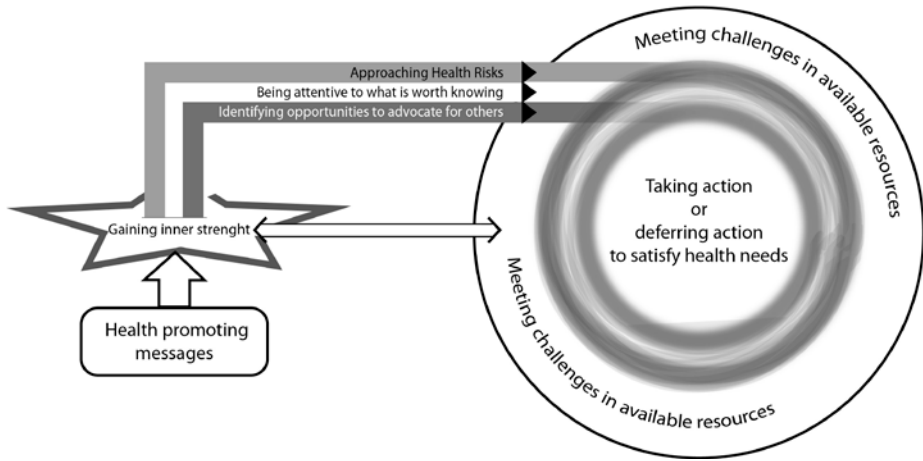


Figure 4. Model visualizing experiences of using health-promoting messages from PAMC program to make health decisions in everyday life.

6.4 Program effect on activities of daily living and self-rated health

No significant differences were identified between the intervention and control groups for maintenance in ADL. In line with the inclusion criteria, all participants were independent in ADL at the study baseline and a high proportion of the participants maintained independence at both the 6-month and 1-year follow-ups. The proportion depended on the method used. The MCD analysis, which contributed to the lowest proportion of maintained independence, showed that the majority of participants in both the intervention and control groups, 68% and 72%, respectively, were independent at the 1-year follow-up. Comparative values when LOCF was used to impute values were 86% and 89% in the intervention and control groups, respectively. See table 6 for further details.

Table 6. Proportion (%), odds ratio (OR), 95% confidence interval (CI), and p-value for maintained independence in activities of daily living at 6 months and 1 year between control group and intervention group presented for complete case analysis and two different imputation methods.

Analysis method	Maintained independence in ADL at follow-up	Control group ¹	Intervention			
		n (%)	n (%)	OR	CI (OR)	p
MCD						
n=131	6 months	53 (71)	42 (75)	1.25	0.57-2.72	0.583
	1 year	54 (72)	38 (68)	0.82	0.39-1.75	0.608
LOCF						
n=131	6 months	65 (87)	50 (89)	1.28	0.44-3.76	0.651
	1 year	67 (89)	48 (86)	0.72	0.25-2.04	0.533
CC						
n=109²	6 months	53 (85)	42 (89)	1.43	0.44-4.58	0.550
n=104³	1 year	54 (92)	38 (84)	0.5	0.15-1.7	0.269

¹Reference group (1.00)

²control n=62, intervention n=47

³control n=59, intervention n=45

Abbreviations: ADL, activities of daily living; MCD, median change deterioration;

LOCF, last observation carried forward; CC, complete case analysis

No significant differences were identified between the intervention and control groups for maintenance or improvement in self-rated health. At baseline self-rated health varied from poor to excellent with a median value reflecting good health for both groups. All three analysis methods showed that more than half of the participants in both groups maintained or improved self-rated health at the 6-month and 1-year follow-ups, although the proportion did depend on the method used.

The MCD analysis, showed that the majority of participants in both the intervention (51%) and control groups (54%) maintained or improved their self-rated health at the 1-year follow-up. Comparative values when LOCF was used to impute values were 68% in both groups. See table 7 for further details.

Table 7. Proportion (%), odds ratio (OR), 95% confidence interval (CI), and p-value for maintenance or improvement in self-rated health at 6 months and 1 year between control group and intervention group presented for complete case analysis and two different imputation methods.

Analysis method	Maintenance or improvement in self-rated health at follow-up	Control group ¹	Intervention	OR	CI (OR)	<i>p</i>
		n (%)	n (%)			
MCD						
n=131	6 months	42 (56)	33 (59)	1.13	0.56–2.27	0.738
	1 year	38 (51)	30 (54)	1.12	0.56–2.25	0.742
LOCF						
n=131	6 months	55 (73)	40 (71)	0.91	0.42–1.97	0.809
	1 year	51 (68)	38 (68)	0.99	0.47–2.09	0.986
CC						
n=108²	6 months	42 (69)	32 (68)	0.97	0.43–2.19	0.932
n=105³	1 year	37 (62)	28 (62)	1.02	0.46–2.27	0.954

¹Reference group (1.00)

²control group n=61, intervention n=47

³control group n=60, intervention n=45

Abbreviations: MCD, median change deterioration; LOCF, last observation carried forward; CC, complete case analysis

7 DISCUSSION

The findings from this thesis contributed to gaining an in-depth understanding of how to support knowing and doing to promote health among older people aging in the context of migration. Two approaches to address health-related interventions targeting people who have immigrated are described in the literature. First, services could be specifically aimed at the target population. Second, existing health services could be adapted to welcome diversity (120). Congruent with the ethics of a person-centered approach (15, 43) and knowledge that the meaning and value of occupation will most likely vary both from person to person and during one's life course (42, 47), the second approach was applied in this thesis. Taking into account the heterogeneity among older people aging in the context of migration (27), our goal was to gain in-depth knowledge about how to provide evidence-based health promotion to support optimal aging. Thus, this thesis adds to the current knowledge base of how to support program development and implementation, and how to design and evaluate health promotion programs targeting older people aging in the context of migration. Findings also contribute to the discussion of when, where, and to whom health promotion programs aimed at supporting optimal aging should be offered.

7.1 Adapting a program in partnership

One of our main findings (study I) was how negotiations were used as a way to support suitable program adaptations. Similar to previous findings (121), we found that a researcher-community partnership could help improve the usefulness of exchanged knowledge. Researcher-community partnerships are advocated to develop services (63, 122), particularly because they can enable ongoing negotiations (123). However, this is the first known study to demonstrate how and why such a negotiation process between researcher-community partners contributes to program adaptations in support of optimal aging in the context of migration.

The category *establishing a common ground to shape adaptation*, showed how prerequisites for working in partnership were created (i.e., merging the expertise of different partners into negotiations). Despite researcher-community partnerships being advocated (70, 123), as far as we know only one study (124) have explored how practitioners and researchers collaborate when implementing a complex intervention. In addition, none have specifically investigated complex interventions targeting older people aging in

the context of migration. However, Eriksson et al. (124) recently explored occupational therapists' experiences of collaborating with researchers in their role as implementers of a complex intervention targeting activities of daily living. Similar to our study, Erikson et al. (95) showed that establishing a partnership was a process that moved from being an outsider to the scientific world, to being included, and then to becoming an integrated partner (124). Our results also highlighted a process of approaching each other's realities expressed by both researchers and practitioners, in which active effort was required to experience adaptations as a joint effort.

The results (study I) contributed both to an in-depth understanding of reasons that drive the negotiation process, and how the outcome of negotiations contributed to adaptations to program content and design. Three reasons (*to meet needs and resources, to defend core components, and to advocate evaluability*) supported or inhibited actions that influenced which final adaptations were performed. Adapting programs to meet target groups' needs has been previously reported (63, 76), as has support of program component implementation (76, 83, 122) and the challenge for researcher to balance methodological rigor with responsiveness to the community (125). However, to the best of our knowledge, no study has reported how a researcher-community partnership contributes to the interplay within and between these previously mentioned reasons to adapt and how the reasons to adapt are linked to performed adaptations.

7.2 Contextual influences on implementation

Findings (study I–IV) highlight various perspectives regarding contextual prerequisites on implementation. The implementation process of evidence-based practice is complex, with possible various contextual influences (126, 127). The context in which an intervention is implemented is described to both facilitate and inhibit the implementation of evidence to practice (70, 74). The concept of context can be understood in different ways, from the characteristics of the environments where changes take place, to the theoretical underpinnings of the intervention being implemented or the implementation strategy used (76).

First, context can be understood as the environment where changes take place. This study took place in a low socioeconomic area where most residents were born abroad and generally had a low educational level (18). Older people born abroad often face poorer living conditions than their native-born counterparts (30, 57), and language is described as a barrier to access to health services and health information (11, 26, 61). The influence

of socioeconomics and language differences as potential health promotion barriers was shown in relation to program implementation (study I). Adaptations were performed to bridge these barriers. For example, information about health-promoting activities were given at no charge, and senior meetings were planned at times when public transportation was free. Choices were also provided for how health-promoting messages could be exchanged according to language skills, functional ability, and previous experience (study I). In Sweden, municipalities are responsible for providing services for those in need, and older people born abroad are entitled to the same formal rights as native-born residents (128, 129). Our results present solutions to bridging barriers to such services, but also highlight, similar to previous studies (130, 131), remaining challenges with regard to using health promotion to reach out to the target group and to recruit participants (studies I and IV).

Second, context can be understood as the theoretical underpinning of intervention, here referred to as program core components such as peer-learning and person-centeredness. Peer-learning has been shown to contribute to supportive environments for learning by enabling peer interaction (132). Our results (study II) confirm previously described advantages of peer-learning, such as peers being considered a credible source of information and learning through interactions with others in a group (132-134). In addition, peer-learning in combination with interprofessional learning highlighted the importance of being able to choose how one wished to exchange knowledge, with whom, and about what. The opportunities to understand and be understood were therefore facilitated using a bilingual approach, multidimensional content, and various pedagogical approaches including both the ability to share one's expertise with peers and to exchange health-promoting messages with an interprofessional team. Thus, an interprofessional team supporting peer-learning combined with group meetings relying on a person-centered approach appears to be advantageous.

Research advocate a person-centered approach for acknowledging diversity among older people (2, 16, 68), and identifying each person's capabilities for optimal aging (16). This is consistent with our finding that a person-centered approach supported the exchange of health-promoting messages to be contextually valid and of value for the participants (studies II–III). Similar to other findings, challenges to implementing a person-centered approach existed (135-137), which became increasingly complex considering the contextual influences of performing health promotion in a group and by using different languages during the group meetings (studies I–II). Telling and listening are central to a person-centered approach in order to create a

common understanding; in turn, this common understanding should serve as a platform for shared decision making between health professionals and people in need of health promotion (15, 138). This is also true for peer-learning, which relies on interaction between participants (69), who, according to our results, also preferred to speak different languages during the meetings (study II). Merging study I and II findings, the adaptations bridged barriers to group-based health promotion with a person-centered approach.

Third, contextual prerequisites could be understood as the theoretical underpinning of implementation strategy. This thesis built upon a collaborative approach and used the researcher-community partnership as an implementation strategy (139). This implementation strategy is based on a constructivist view of learning, i.e., knowledge is distilled, shaped, and reconstructed by existing understanding and experiences (1). Active partnerships between health professionals and universities were considered major enablers for evidence-based practice. This could be because opportunities to engage in research projects meaningful for practice, promotes dialogue on the meaning of knowledge and evidence that may support clinical decision making (121).

The PAMC program (18) was developed in response to an existing need to provide health promotion targeting older people aging in the context of migration. Thus, the PAMC program can be regarded as facilitating integration of research evidence, professional experiences, and values and preferences of the targeted group. Our findings (study I) showed that learning occurred not only because of knowledge exchange between the health personnel, research team, and steering committee, but also because other partners (e.g., interpreter services and older people born abroad) were able to participate in implementing health promotion. For example, person-centered dialogue (15) with people in the target population resulted in changing the initial focus of adaptations that concerned culture, and educational and linguistic needs by identifying both needs and resources in order to shape adaptations (study I). Thus, consistent with previous literature (140), one advantage of using a person-centered approach was the ability to counteract stereotypes by changing the focus from what to adapt for and to whom to adapt with. The advantages of involving older people born abroad in program development and as active partners during program execution also raises questions about the role of participants in health promotion as influencing program implementation and sustainability. This question is also noted in implementation literature; currently, almost none implementation frameworks incorporate the target group that should benefit from the

implemented intervention (1). Our results (studies I–II) highlight the need to further investigate the target group’s role in such frameworks.

7.3 Experienced benefits of PAMC

Our results contribute knowledge on how older people aging in the context of migration benefit from the program to age optimally (study II). In addition, we demonstrated how health-promoting messages could be integrated from the program into everyday life (study III). For knowledge translation to enhance health services, knowledge should be adapted to the participating person’s context (17). There is also a need to consider the uniqueness of each person in order to support optimal aging (45, 16).

Our findings showed that three health-promoting processes were initiated (*enabling community, providing opportunity to understand and be understood, and confirming human value and ability*) and identified as raising awareness during the program (study II). The continuation of these processes into everyday life resulted in participants *gaining inner strength* (study III). Previous studies (4–6) have highlighted the importance of health promotion programs, but the mechanism of what works and for whom in such programs has remained unknown (5, 64). Our finding is the first to show how older people experience program content and design to promote health during the program and in everyday life (studies II–III). Two of the processes started during the program (study II) were in line with the expected outcome of the PAMC study, focusing on learning strategies or being empowered to manage everyday life (18). In contrast, the third process *enabling community* was not related to learning but helped participants establish social contacts with peers or health professionals. The opportunity to interact with other people was sometimes the strongest motivation for participation. This finding is strengthened by previous literature describing community as a means to experience health or to meet other people with similar experiences (66, 141, 142). In addition, previous literature (143) show the importance for being engaged in occupations which provide opportunities for people aging in the context of migration to build relationships in order to be connected to meaningful places. This suggests that the PAMC program can be seen as both the means and goal for meaningful occupation. Further, we found that participants searched for and used knowledge to advocate other’s health (studies II–III), which was an unexpected outcome. However, these findings are congruent with previous literature that describe older people’s values as being both the ability to manage everyday life (66, 144, 145) and/or to

support other people's well-being to experience health (66). This indicates that the program gave opportunities to promote participants' valued goals.

The finding that health promotion messages were used as a decision-making tool in everyday life, i.e., to act now or to defer action to satisfy one's health needs (study III), could be interpreted as the PAMC program influencing participants' health literacy. Health literacy entails knowledge, motivation, and competence to access, understand, appraise, and apply health information to make decisions (e.g., health promotion to stay healthy) and is developed through the environment and person interacting (146). Health literacy has already been recognized as being linked to health outcomes (147), as have health-promoting programs been recognized as being useful for supporting health literacy (148). Our findings showed that the PAMC program (18) supported health literacy in everyday life among older people aging in the context of migration, by directing people's attention towards information of importance to help approach one's own health risks or advocate other's health. Therefore, the aim of providing tools to support decisions was to promote doing health promotion and being healthy in everyday life. Enabling people to make choices and to be in control of their decisions and lives is central to a person-centered approach to health promotion. From this perspective, providing people with the ability to prioritize and make health decisions are goals and not behavioral changes per se (138). Our findings (studies II–III) indicate that this goal was met.

7.4 The effect of PAMC on doing and health in everyday life

One main finding was that the intervention demonstrated no significant effect for either independence in daily activities or self-rated health (study IV). A possible reason for this is that the intervention actually had no effect, but other explanations are possible. Lessons were learned during the recruitment and implementation phases of the study and contributions from qualitative evaluations (studies II–III). These lessons included how factors such as the age of the target group, the timing of the intervention, and the selected outcome variables together with other methodological shortcomings might have prevented detection of both ADL and self-rated health effects. This provides implications for both practice and future research.

The timing of intervention and inclusion age need to be discussed to gain in-depth knowledge into when, and to whom the intervention should be provided. Being able to offer health promotion in the early stages of age-

related decline, before a person becomes frail or dependent on assistance in daily activities, is highlighted in the literature (149, 150). The inclusion age was lowered in the PAMC program compared with the original protocol (study I). This decision was based on the assumption stated in previous literature (11, 57, 151) and professional experiences that drew attention to how older people aging in the context of migration may be doubly vulnerable and more prone to ill health compared with their native-born counterparts. Our results may have proven this assumption incorrect because most participants maintained or improved their self-rated health and continued to be independent in ADL (study IV). It is possible that older migrants from the target group have more resources, within themselves and their environment, and are less vulnerable than previously thought. This fact has been raised previously as a critique that it often taken as a truth that older immigrants live under more disadvantaged conditions than their Swedish peers and are considered as having special needs, even if there are enormous differences among them (27). Both the country of birth and the country of residence after migration affect frailty (35), and factors such as access to education, work, and health services both in the country of birth and country of residence might influence a person's health capabilities. Migration experience is another aspect that could influence health during the aging process (145, 152). In our study (IV), most participants (87%) had been living in Sweden for a long time and the majority (37%) were labor migrants. The decision to lower the inclusion age to 70 years is one possible reason for why no significant difference was found. This would constitute an incentive to adjust the suitable target age for offering health promotion interventions such as those in this study to people aging in a migration context to ≥ 75 years. This recommendation requires careful deliberation because the present study included only people born in Finland and the Western Balkans, and other possible important or interacting factors affecting the result should also be considered.

In addition, the null result might also be explained by the choice of outcome measures because the program targeted independent living people aged ≥ 70 years. Activities of daily living can be considered a well-established and common outcome measure in occupational therapy practice (153). However, based on the findings of qualitative studies (II–III), staying healthy and independent was a long-term goal because participants were still living independently and most had no activity limitations (study IV). Therefore, the dichotomous outcome of the nine activities (dependence/independence) measured in the ADL-staircase (104, 105) may be too rough of a measure despite maintenance of independence in ADL being important to the target group (66, 145). Additional activity dimensions, such as feeling secure when

performing them or performing them without fatigue, may have been more sensitive outcomes for the target group. Additionally, other occupations such as leisure activities, or being able to help a next of kin, constituted more meaningful occupations, as learned by the qualitative findings (study II–III). A more person-centered approach to occupation with the possibility of capturing individual preferences of daily activities could have been a better choice. Two alternative measures that would allow personal goal-setting and estimates of progress in self-selected activities are the Canadian Occupational Performance Measure (154) or Goal Attainment Scaling (155). These instruments may have been more suitable for capturing subtle changes in daily activities of relevance for participants in their everyday lives.

7.5 Methodological considerations

7.5.1 Using a mixed method approach

A methodological strength of this thesis was that a mixed-method approach (156) was applied, by combining qualitative (studies I–III) and quantitative methods (IV), to answer the overall aim. Both quantitative and qualitative approaches have their individual strengths and weaknesses, yet greater utility may occur when both are used together (14, 84, 157). Although RCTs are often described as the gold standard of evaluation (99), in some areas, such as public health and occupational therapy, it is common for programs to consist of many interacting components i.e., complex interventions (84). Understanding and evaluating the complexity of such programs requires a range of methodological approaches (14, 84). The combination of quantitative and qualitative approaches is sometimes criticized owing to epistemological differences, but the approach could be legitimized (158). This thesis revealed the advantages of combining different approaches when evaluating and exploring the program. The results from studies I–III could be used to deepen the understanding of program outcomes evaluated in the RCT. In addition, they contributed new knowledge that can be used for further program development and tailoring of future implementation strategies. Investigating how the processes identified in studies I–III were influenced by contextual prerequisites would not have been possible with a quantitative approach. Furthermore, the qualitative studies provided opportunities to explore participants' perspectives by involving them as active collaborators throughout the research process, which is recommended in disciplines with person-centered orientations in practice (159).

7.5.2 Methodological challenges and contributions

Immigrants or people with low socioeconomic backgrounds are often underrepresented or excluded from research design and from participating in trials (13, 92). The conduct of this thesis has contributed both opportunities and challenges in terms of research with and about older people aging in the context of migration. Methodological challenges were met in the recruitment procedure, language barriers in data collection, a heterogeneous population, and the transferability and generalizability of findings. These challenges might have influenced the results and may therefore be seen as methodological limitations. However, such methodological challenges need to be dealt with actively, which requires a better understanding of the diverse needs of older populations in research and practice (2), which is covered in this thesis.

As mentioned, one challenge was the recruitment procedure. This was met by applying a pragmatic approach to conducting RCT, meaning that decisions regarding recruitment were renewed due to encountered barriers (18). One such barrier was the identified risk of excluding illiterate individuals on false grounds due to impaired cognition. Therefore, the total score of the Mini-Mental State Examination (106), used as exclusion criteria in the PAMC study, was adjusted to 80% of administrated items in order to compensate for illiteracy (18). Furthermore, actions such as mediating information through local radio stations or associations and cooperation with local health units to reach potential participants and establish contact were taken to support recruitment (102). Three recruitment waves were applied (18). However, despite efforts, we failed to reach power in the RCT, which was a limitation. A multicenter design is one suggestion for future studies focusing on a similar target group. Determining how to best recruit participants needs careful deliberation and further investigation.

How to deal with methodological concerns regarding language was a further challenge. Language barriers are one common reason for excluding people from participating in research (92). A bilingual approach to recruitment and data collection was applied in the PAMC study (18, 102), which was in line with previous recommendations (92, 130). The questionnaire was translated, and the participants chose their preferred language or languages during data collection (18, 102). A methodological contribution of this thesis is determining how to deal with translation and analysis in the qualitative interviews. Translated data are always a limitation (115), but are also a prerequisite for including data from participants with a mother tongue different than that of the researcher. The challenge of combining three languages in data collection and analysis in the grounded theory studies were

overcome by involving project assistants as active partners. This approach improved the quality of the findings by enabling a reflexive stance, for both researchers and translators (95, 160).

Another encountered challenge was reaching heterogeneity in the targeted population. Health is shaped via one's life course and health determinants in the country of birth and host country. Furthermore, personal health behavior and migration experiences might influence health in later life (8, 10, 161). Psychosocial and cultural changes associated with migration can be stressful experiences and can, as well as language problems, affect one's life situation in the host country (56). In addition, educational level and income are considered social determinants for health (50), which were important to consider as this thesis was performed in an area with generally lower educational level and socio-economy (Table 2). Owing to practical reasons, it was only possible to include two language groups in this study. Hence, the choice of exploring and evaluating the PAMC program from the perspective of people representing the two largest immigrant groups in the study setting (18), (i.e., people born in Finland and the Western Balkan region), was considered advantageous. As recommended, this choice allowed us to acknowledge heterogeneity among persons aging in the context of migration (2, 16, 27, 161). Heterogeneity included migration experiences, different language preferences, countries of birth, gender, educational level, as well as age. Participants' characteristics meant that heterogeneity in the PAMC program was reached due to migration experiences, and gender, but it is noted that most participants were aged ≤ 75 years and have been living in Sweden for many years (Table 3). People with poor language skills and people with lower levels of education were probably not included in the PAMC sample. Factors such as language, socioeconomic status, age, past experiences, and cultural background may influence how health information is understood and responded to (162), and might have therefore also influenced adaptations, experiences, and outcomes of the PAMC study. Hence, the findings should be understood with regard to the studied sample.

This thesis was mainly performed in two suburbs of one of Sweden's larger cities (18). Methodological literature highlighted credibility or trustworthiness criteria for judging for whom and in which real-world settings results from research can be used (157). This can be referred to as contextual transferability and generalizability. Context matters and should be taken into account to understand both implementation and evaluation of programs. May et al. (163) states that there are advantages to acknowledging the dynamic nature of contexts and to understand context as a process rather than a place. The combination of methods used in this thesis allowed us to

capture the dynamic nature of contexts through an occupational lens. This thesis contributed different perspectives of what constitutes a context (42, 76) by exploring contextual prerequisites as theories underpinning intervention, implementation strategies used, and by incorporating influences into the local context in which doings are interwoven in the everyday lives of older people. The possibility of exploring contextual influences is central to the qualitative methodologies used (93, 95). Therefore, the qualitative findings (studies I–III) could be used to understand the results in the context in which they were developed, which is seen as strength of this thesis.

8 CONCLUSION

Different findings regarding program evaluation were drawn from qualitative and quantitative studies. Therefore, further studies are needed before a final conclusion on the effect of the program can be determined. Although no effect was demonstrated quantitatively, qualitative studies showed that the target group experienced benefits from the PAMC program. In addition, lessons were learned as to how the content and design contributed to the experienced benefit. Thus, our findings contributed knowledge regarding how to support program development and implementation.

The use of a researcher-community partnership as an implementation strategy was fruitful when it came to supporting the implementation of evidence from the original program as well as in the development of new solutions. Few adaptations were made to the original program. Lowering of the age limit so that we can reach older people aging in the context of migration before they become frail is a decision that needs to be reconsidered. The results also revealed the importance of involving older people aging in the context of migration in program development and implementation. The approach (PAMC) that was negotiated in the researcher-community partnership bridged barriers to health promotion targeting people aging in the context of migration. The provision of choices during the group-meetings was of importance to bridge barriers to exchange of health-promoting messages. Combining peer-learning with inter-professional group meetings based on a person-centered approach is essential for achieving this. During the program, participants could search for and use information they had a reason to value for themselves or their next of kins. This led to raised awareness and supported health-decision making in everyday life, and thus health literacy. Due to these benefits, the PAMC program is recommended for increasing the skills of older people aging in the context of migration to take advantage of rights and opportunities within health services.

9 IMPLICATIONS FOR PRACTICE AND RESEARCH

- Establish researcher-community partnerships to support recruitment, adaptation, implementation, and performance of health promotion programs.
- Be sensitive to personal goals to attend health-promoting services in a group context, such as enabling social gatherings and learning both for self and others.
- Provide choices of what to learn, how to learn, and from whom to learn when setting up health promotion programs.
- Provide choices for program content and design to enable participants to make use of their innate resources; thus possibly compensating for experienced barriers such as illiteracy, low vision, or functional decline.
- Acknowledge participants' language skills in the participant's mother tongue and Swedish as a facilitator in health-promoting group meetings.
- Integrate the interpreter into the team to support the implementation of a person-centered approach and peer-learning in health-promoting group-meetings.
- Future research could benefit from a multicenter design to reach power and increase the probability of attaining valid results.
- Future studies should use outcome measures that capture subtle changes in daily activities relevant to participants' everyday lives.

10 FUTURE PERSPECTIVES

This thesis contributed knowledge of how to support knowing and doing in promotion of health among older people who have migrated to Sweden from Finland or the Western Balkan region. However there is still much to explore and evaluate. The knowledge gained from this thesis points to several areas that require further research.

Firstly, further studies are needed to arrive at a final conclusion on the intervention effect and for whom PAMC is effective. The PAMC program needs to be evaluated in relation to other outcome measures, in older age groups, in a broader population and other settings. Our findings suggest that outcome measures focusing on a persons' ability to "be" and "do" what they consider important is of special interests according to our qualitative findings. Our findings also indicated varying reasons for participation in PAMC and challenges in recruitment. In addition, findings showed benefits of participating in PAMC for persons 70 years or older, but no effect. Therefore it would also be of value to dig deeper into the motives for participation, when to provide health promotion services and how to enhance recruitment rates. There is also a need to further investigate the timing of the intervention quantitatively in a longitudinal perspective.

In addition, there is a need of studies focusing on how to support doing in the older persons everyday life in relation to activities aimed to maintain health, advocating for others and to be able to search and understand health information. Our results showed that there were hindrances in everyday life which inhibited the participants to act on valuable health goals. Thus, future studies should be directed toward exploring hindrances and facilitators on the societal level (macro level), for the use of acquired knowledge in daily life.

Finally, our results supported the importance of involving the target group in dialogs during the implementation process, and that the implemented content and design of PAMC were influenced by both the personnel and the participants' expertise. Currently, few implementation frameworks incorporate the target group that should benefit the intervention. Therefore, future studies should further explore the role persons have who might benefit from the intervention in these frameworks.

TACK

Det är många personer som har bidragit till att det var möjligt att skriva denna avhandling. Nedan vill jag tacka ett antal personer som har varit av särskild betydelse under min doktorandtid så väl på ett professionellt som ett personlig plan.

Först och främst vill jag tacka alla er som deltog i, eller arbetade med PAMC för att ni har delat er tid och era erfarenheter.

Jag vill även rikta ett varmt tack till mina tre fantastiska handledare; *Synneve Dublin-Ivanoff, Susanne Gustafsson och Lars Wallin.*

Synneve, tack för att du har låtit mig flyga högt och fritt samtidigt som du har hållit i min lina. Du har en fantastisk förmåga att möta mig där jag är och att plocka fram mina styrkor. Vetskapen om att du alltid finns där för mig och din inställning att det finns lösningar till allt har gjort att jag har vågat utmana mig själv. *Susanne*; du har utgjort en trygghet och stabilitet som jag har kunnat luta mig mot när det har blåst hårt. Du har lärt mig om vikten av att acceptera kaoset och har genom ditt driv, din spontanitet och nyfikenhet utgjort en positiv kraft som jag har gett mig energi och mod att våga tänka utanför boxen. Tack också för alla förlösande skratt. *Lars*; du har utgjort en frisk fläkt i mitt handledarteam genom att tillföra ett annat perspektiv och en dynamik i gruppen. Dina kloka frågor har startat reflektioner som har drivit mig framåt. Jag tar även med mig din uppmaning att klippa hängslena.

Jag vill även tacka min medförfattare *Elisabeth Björk Brämberg* för att du delat dina erfarenheter. Tack också för ditt tålamod att låta degen jäsa och knådas samt för att du brydde dig om mig både som person och kollega under den tuffaste tiden av min utbildning.

Ett stort tack till Er projektassistenter som jobbat tillsammans med mig. *Anna*; tack för ditt engagemang, din noggrannhet samt givande diskussioner och skratt på såväl ett professionellt som ett privat plan. *Zoran* tack för din omtänksamhet och hjälpsamhet, och för otaliga timmar av transkribering. *Maida* tack för att du alltid är så serviceminded. Du har varit till stor hjälp med såväl intervjuer, översättningar samt frågor om databasen.

Gunilla Gosman-Hedström, tack för att du har följt mig under doktorandtiden. Du har en glöd och ett engagemang som smittar av sig och har varit en betydelsefull lots in i den akademiska världen.

Theresa Westgård, det har varit oerhört värdefullt att kunna diskutera språkliga innebörder och att få hjälp med språkgranskning av dig. Tack även för att du sprider positiv energi och glädje omkring dig, det förgyller vardagen.

Till mina nuvarande och tidigare chefer och kollegor på SU. Det har betytt mycket att känna ert stöd och höra era hejarop. Ett extra tack till dig *Helga*; du kan både sporra mig och bromsa mig, vilket har fått mig att växa.

Tidigare och nuvarande kollegor och vänner på GU: Tack för samarbete, givande diskussioner om jobb och vardag, administrativt stöd, energigivande kramar samt uppmuntrande ord i tal och skrift. Ni har gjort denna resa så mycket lättare och roligare. Jag är så glad att ni alla har funnits där för mig, ingen nämnd och ingen glömd.

Ett speciellt tack till er kollegor som under halvtidsseminarium och predispotation har granskat mina arbeten; *Anna-Lisa Thorén-Jönsson*, *Carin Willén*, *Kristina Rosengren*, *Kristina Holmgren* och *Marie Peny-Dahlstrand*. Extra tack till dig *Marie* för support och roligheter under min första konferens.

Tack även till *alla mina doktorandkollegor* som bidragit med konstruktiv feedback under seminarier och för draghjälp och sällskap när vi har läst kurser ihop. Ett extra tack till dig *Annikki* för spännande diskussioner och hjälp med översättning.

Jag vill även rikta ett tack till dig *Andreas*, för att du tålmodigt har lyssnat när mina tankar har gått i spinn. Din galna humor, ditt lugn och dina frågor har gett mig energi och fokus på upploppet.

Tack också till min underbara GU-family för vänskap i vått och torrt samt för givande diskussioner: *Iolanda*, tack för att jag har fått sola mig i din energi, glädje och värme. Du förstår mig utan att jag behöver använda ord. Din vägledning om hur jag kan placera mig har gett mig luft under vingarna och lyft mig framåt. *Isabelle*, tack för att du med omtänksamhet, värme och humor har guidat mig till doktorandlivets oaser. Det har varit guld värt både att få gå bredvid dig och att följa i dina spår. *Daniela* tack för att du genom ärlighet, kärlek och närvaro har hjälpt mig utvecklas på flera plan. Ditt mantra *all we need is love* finns med mig och *"It is like that with love – we may be close, we may be far but our love still surrounds us wherever we are"*. Det gäller även för dig *Qarin*, som räknat i mil befinner dig långt bort, men som trots det ändå alltid är nära mig. Tack för att du får mig att känna att jag är mer än vad jag själv förstår. Du utmanar och inspirerar mig och hjälper till att hålla glöden levande i med- och motvind.

Till *släkt och vänner* som jag inte har nämnt vid namn här men som på olika sätt har hjälpt mig under min doktorandtid. Tack för samtal om livet och jobb. Tack för praktisk hjälp. Tack för att ni drar mig ut på roligheter och tack för att ni har haft förståelse för att jag ibland har behövt vara i min egen bubbla. Ni betyder mycket för mig!

Till *min älskade familj* som alltid finns vid min sida och fyller mig med kärlek, energi och hopp. Utan er hade jag varken varit den jag är idag eller där jag är idag. *Mamma, pappa och Marie*, tack för att ni stöttar mig i vått och torrt. Jag uppskattar att ni har uppmuntrat mig att följa den väg jag har valt samtidigt som ni har hjälpt mig att se på mig själv i ett utifrån perspektiv när "tävlingsdjävulen" eller doktorandbubblan har tagit överhand. *Julian* och *Nicoline*, tack för att ni varje dag påminner mig om vad som är viktigt i livet och att jag tillsammans med er får upptäcka världen ur nya perspektiv. Jag älskar er av hela mitt hjärta. *Johan*, "*You lift my spirit. You melt the ice. When I need inspiration when I need advice*". Du är min klippa. Tack för att vi väljer varandra varje dag och för att du alltid stöttar mig i det jag väljer att göra. Jag älskar dig och som du sa; Vad hade du (Emmelie) klarat utan mig ;-). Extra tack också för praktisk hjälp med layout, figurerna i mina artiklar, bilden på framsidan och för otaliga timmar av it-support.

REFERENCES

1. Nilsen P. Implementering av evidensbaserad praktik [Implementation of evidence-based practice] (In Swedish). 1 ed. Falkenberg: Team Media Sweden AB; 2014.
2. World Health Organization. World report on aging and health. Luxemburg: World Health Organization; 2015.
3. World Health Organization. Knowledge translation framework for aging and health. Luxemburg: World Health Organization; 2012.
4. Gustafsson S, Eklund K, Wilhelmson K, Edberg AK, Johansson B, Häggblom-Kronlöf G, Gosman-Hedström G, Dahlin-Ivanoff S: Long-Term Outcome for ADL Following the Health-Promoting RCT--Elderly Persons in the Risk Zone. *The Gerontologist*. 2013;53(4):654-63.
5. Beswick AD, Rees K, Dieppe P, Ayis S, Gooberman-Hill R, Horwood J, et al. Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet*. 2008;371(9614):725-35.
6. Huss A, Stuck AE, Rubenstein LZ, Egger M, Clough-Gorr KM. Multidimensional preventive home visit programs for community-dwelling older adults: a systematic review and meta-analysis of randomized controlled trials. *Journals of Gerontology Series A Biol Sci Med Sci*. 2008;63(3):298-307.
7. Sen A. The idea of justice. Cambridge: Belknap Press of Harvard University Press; 2009.
8. Giannoni M, Franzini L, Masiero G. Migrant integration policies and health inequalities in Europe. *BMC Public Health*. 2016;16(1):463.
9. Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P, Consortium European Review S, et al. WHO European review of social determinants of health and the health divide. *Lancet*. 2012;380(9846):1011-29.
10. Bennett KM, Scornaiencki JM, Brzozowski J, Denis S, Magalhaes L. Immigration and its Impact on Daily Occupations: A Scoping Review. *Occupational Therapy International*. 2012;19(4):185-203.
11. Alizadeh-Khoei M, Mathews RM, Hossain SZ. The Role of Acculturation in Health Status and Utilization of Health Services among the Iranian Elderly in Metropolitan Sydney. *Journal of Cross-Cultural Gerontology*. 2011;26(4):397-405.
12. Law MC, MacDermid J. Evidence-based rehabilitation: a guide to practice. Thorofare, NJ: Slack; 2008.
13. Rogers WA. Evidence Based Medicine and Justice: A Framework for Looking at the Impact of EBM upon Vulnerable or Disadvantaged Groups. *Journal of Medical Ethics*. 2004;30(2):141-5.
14. Brownson RC, Baker EA, Leet TL, Gillespie KN, True WR. Evidence-based public health. Oxford: Oxford University Press; 2011.
15. Ekman I, Swedberg K, Taft C, Lindseth A, Norberg A, Brink E, et al. Person-centered care -ready for prime time. *European Journal of Cardiovascular Nursing*. 2011;10(4):248.
16. Lood Q, Dahlin-Ivanoff S, Dellenborg L, Mårtensson L et al: Health-promotion in the context of ageing and migration: a call for person-centred integrated practice. *International Journal of Integrated Care*. 2014; 14:e004.
17. Metzler MJ, Metz GA. Translating knowledge to practice: An occupational therapy perspective. *Australian Occupational Therapy Journal*. 2010;57(6):373-9.
18. Gustafsson, Lood Q, Wilhelmson K, Häggblom-Kronlöf G, Landahl S, Dahlin-Ivanoff S. A person-centred approach to health promotion for persons 70+ who have migrated to Sweden: promoting aging migrants' capabilities implementation and RCT study protocol. *BMC Geriatrics*. 2015;15(1):10-.
19. Dahlin-Ivanoff S, Gosman-Hedström G, Edberg AK, Wilhelmson K, Eklund K, Duner A, et al. Elderly persons in the risk zone. Design of a multidimensional, health-promoting, randomised three-armed controlled trial for "prefrail" people of 80+ years living at home. *BMC Geriatrics*. 2010;10:27.
20. Gustafsson S, Wilhelmson K, Eklund K, Gosman-Hedström G, Zidén L, Kronlöf GH, et al. Health-promoting interventions for persons aged 80 and older are successful in the short term-results from the randomized and three-armed elderly persons in the risk zone study. *Journal of the American Geriatrics Society*. 2012;60(3):447-54.

21. Behm L, Wilhelmson K, Falk K, Eklund K, Zidén L, Dahlin-Ivanoff S: Positive health outcomes following health-promoting and disease-preventive interventions for independent very old persons: Long-term results of the three-armed RCT Elderly Persons in the Risk Zone. *Archives of Gerontology and Geriatrics*. 2014;58(3):376.
22. Zidén L, Häggblom Kronlöf G, Gustafsson S, Lundin-Olsson L, Dahlin-Ivanoff S, Sahlgrenska A, et al. Physical Function and Fear of Falling 2 Years After the Health-Promoting Randomized Controlled Trial: Elderly Persons in the Risk Zone. *The Gerontologist*. 2014;54(3):387.
23. Hawe P, Potvin L. What Is Population Health Intervention Research? *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*. 2009;100(1):18-114.
24. Eccles MP, Armstrong D, Baker R, Cleary K, Davies H, Davies S, et al. An implementation research agenda. *Implementation Science*. 2009;4(1):18.
25. Nilsen P. Implementering: teori och tillämpning inom hälso- och sjukvård [Implementation: theory and application in health-care services] (In Swedish). Lund: Studentlitteratur; 2010.
26. Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. *Lancet*. 2013;381(9873):1235-45.
27. Torres S. Elderly immigrants in Sweden: 'Otherness' under construction. *Journal of Ethnic and Migration Studies*. 2006;32(8):1341-58.
28. Statistics Sweden. The future population of Sweden 2012-2060. Stockholm: Statistics Sweden; 2012.
29. Ekberg J. Invandring till Sverige - orsaker och effekter [Immigration to Sweden - causes and effects] (In Swedish). Årsbok från forskningsprofilen AMER. Växjö: Växjö Universitet. Press; 2003.
30. Statistics Sweden. Integration - foreign born persons of retirement age. Statistics Sweden: 2012.
31. Bengtson VL, Gans D, Putney N, Silverstein M. Handbook of theories of aging: New York: Springer Publishing Company; 2008.
32. Kristensson J. Organisatoriska aspekter av äldres vård och hälsa. In: Ekwall A, editor. Äldres hälsa och ohälsa - en introduktion till geriatrisk omvårdnad [Organisational aspects of elderly care and health, the elderly and ill health - an introduction to geriatric nursing] (In Swedish). Lund: Studentlitteratur AB; 2010.
33. Phelan EA, Anderson LA, Lacroix AZ, Larson EB. Older Adults' Views of "Successful Aging"—How Do They Compare with Researchers' Definitions? *Journal of the American Geriatrics Society*. 2004;52(2):211-6.
34. Alftberg Å. Vad är det att åldras?: en etnologisk studie av åldrande, kropp och materialitet [What is aging? An ethnological study of aging, body and material] (In Swedish) [dissertation on the internet]. Lund: Lunds Universitet; 2012. [cited 2016-11-01] Available from: [http://portal.research.lu.se/portal/sv/publications/vad-ar-det-att-aaldras--en-etnologisk-studie-av-aaldrande-kropp-och-materialitet\(08ab2157-84c8-4e58-806f-5d962e26c540\).html](http://portal.research.lu.se/portal/sv/publications/vad-ar-det-att-aaldras--en-etnologisk-studie-av-aaldrande-kropp-och-materialitet(08ab2157-84c8-4e58-806f-5d962e26c540).html)
35. Brothers TD, Theou O, Rockwood K. Frailty and migration in middle-aged and older Europeans. *Archives of Gerontology and Geriatrics*. 2014;58(1):63-8.
36. Morley JE, Evans J, Fried LP, Guralnik JM, Katz PR, Malmstrom TK, et al. Frailty consensus: a call to action. *Journal of the American Medical Directors Association*. 2013;14(6):392-7.
37. Fried LP, Tangen CM, Walston J, Newman AB, Hirsch C, Gottdiener J, et al. Frailty in older adults: evidence for a phenotype. *Journals of Gerontology Series A Biol Sci Med Sci*. 2001;56(3):146-56.
38. Rockwood K. What would make a definition of frailty successful? *Age Ageing*. 2005;34(5):432-4.
39. Markle-Reid M, Browne G. Conceptualizations of frailty in relation to older adults. *Journal of Advanced Nursing*. 2003;44(1):58-68.
40. Behm L, Eklund K, Wilhelmson K, Zidén L, Gustafsson S, Falk K, et al. Health Promotion Can Postpone Frailty: Results from the RCT Elderly Persons in the Risk Zone. *Public Health Nursing*. 2016;33(4):303-15.
41. Stuck AE, Minder CE, Peter-Wuest I. A randomized trial of in-home visits for disability prevention in community-dwelling older people at low and high risk for nursing home admission. *Archives of Internal Medicine*. 2000;160(7):977.
42. Townsend EA, Polatajko HJ. Enabling occupation II: advancing an occupational therapy vision for health, well-being & justice through occupation. Ottawa: CAOT Publications ACE; 2007.
43. Ricoeur P. Homo capax: texter av Paul Ricoeur om etik och filosofisk antropologi. [Homo capax: texts by Paul Ricoeur on ethics and philosophical anthropology] (In Swedish) [Uggla BK, trans.] Göteborg: Daidalos; 2003.
44. Sen A. Capability and Well-being. In: Nussbaum M, Sen A, editors. *The Quality of Life*. Oxford: Clarendon Press; 1993.

45. Brummel-Smith K. Optimal aging, part I: Demographics and definitions. *Annals of Long-Term Care*. 2007;15(11):26-8.
46. Rowe JW, Kahn RL. Successful aging. *The Gerontologist*. 1997;37(4):433-40.
47. Kielhofner G. Model of human occupation: theory and application. Baltimore, MD: Lippincott Williams & Wilkins; 2008.
48. Wilcock AA, Hocking C. An occupational perspective of health. Thorofare, N.J: Slack; 2015.
49. Baltes P FA, Li S-C. The psychological science of human ageing. In: Johnson ML BV, Coleman PG, Kirkwood TBL, editors. *The Cambridge handbook of age and ageing*. Cambridge: Cambridge University Press; 2005. p. 47–71.
50. World Health Organization. The Ottawa Charter for Health Promotion [Internet]: Ottawa: World Health Organization; 1986. [cited 2016-11-08] Available from: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>.
51. Wilcock AA. Occupation for Health. *British Journal of Occupational Therapy*. 1998;61(8):340-5.
52. Yexxa EJ. An introduction to occupational science, a foundation for occupational therapy in the 21st century. *Occupational therapy in health care*. 1990;6(4):1-17.
53. World Health Organization. ICF: international classification of functioning, disability and health. Geneva: World Health Organization; 2001.
54. Christiansen CH, Hammecker CL. Self care. In: Functional performance in older adults. In Bonder BR, Wagner M, editors. Philadelphia: F. A. Davis; 2001. p. 155–175.
55. Prah Ruger J. Health Capability: Conceptualization and Operationalization. *American Journal of Public Health*. 2010;100(1):41-9.
56. Bhugra D. Migration, distress and cultural identity. *British Medical Bulletin*. 2004;69:129-41.
57. Silveira E, Skoog I, Sundh V, Allebeck P, Steen B. Health and well-being among 70-year-old migrants living in Sweden - Results from the H 70 gerontological and geriatric population studies in Göteborg. *Social Psychiatry and Psychiatric Epidemiology*. 2002;37(1):13-22.
58. Hocking C. Occupation for public health. *New Zealand Journal of Occupational Therapy*. 2013;60(1):33.
59. Tucker P, Vanderloo LM, Irwin JD, Mandich AD, Bossers AM. Exploring the nexus between health promotion and occupational therapy: Synergies and similarities. *Canadian Journal of Occupational Therapy*. 2014;81(3):183-93.
60. World Health Organization. Milestones in health promotion: Statements from global conferences. Geneva: WHO Press; 2009. [cited 2016 Nov 05]. Available from: http://www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf?ua=1.
61. Kreps GL, Sparks L. Meeting the health literacy needs of immigrant populations. *Patient education and counseling*. 2008;71(3):328-32.
62. Lood Q, Häggblom Kronlöf G, Dahlin-Ivanoff S. Health promotion programme design and efficacy in relation to ageing persons with culturally and linguistically diverse backgrounds: a systematic literature review and meta-analysis. *BMC Health Services Research*. 2015;15(1):560.
63. Liu JJ, Davidson E, Bhopal RS, White M, Johnson MRD, Netto G, et al. Adapting health promotion interventions to meet the needs of ethnic minority groups: Mixed-methods evidence synthesis. *Health technology assessment*. 2012;16(44):1-469.
64. Clark F, Jackson J, Carlson M, Chou C-P, Cherry BJ, Jordan-Marsh M, et al. Effectiveness of a lifestyle intervention in promoting the well-being of independently living older people: Results of the Well Elderly 2 Randomised Controlled Trial. *Journal of epidemiology and community health*. 2012;66(9):782-90.
65. Clark F, Azen SP, Carlson M, Mandel D, LaBree L, Hay J, et al. Embedding health-promoting changes into the daily lives of independent-living older adults: Long-term follow-up of occupational therapy intervention. *Journals of Gerontology - Series B Psychological Sciences and Social Sciences*. 2001;56(1):P60-3.
66. Lood Q, Häggblom-Kronlöf G, Dellenborg L. Embraced by the past, hopeful for the future: meaning of health to ageing persons who have migrated from the Western Balkan region to Sweden. *Ageing and Society*. 2015:1-17.
67. Kulla G, Sarvimäki A, Fagerström L. Health resources and health strategies among older Swedish-speaking Finns – a hermeneutic study. *Scandinavian Journal of Caring Sciences*. 2006;20(1):51-7.
68. Leplege A, Gzil F, Cammelli M, Lefevre C, Pachoud B, Ville I. Person-centredness: Conceptual and historical perspectives. *Disability and Rehabilitation*. 2007;29(20-21):1555.
69. Shiner M. Defining peer education. *Journal of Adolescence*. 1999;22(4):555-66.

70. Graham ID, Logan J, Harrison MB, Straus SE, Tetroe J, Caswell W, et al. Lost in knowledge translation: time for a map? *The Journal of continuing education in the health professions.* 2006;26(1):13-24.
71. Lencucha R, Kothari A, Rouse MJ. Knowledge translation: A concept for occupational therapy? *American Journal of Occupational Therapy.* 2007;61(5):593-6.
72. Sackett DL, William MCR, Gray JAM, Haynes RB, Richardson WS. Evidence Based Medicine: What It Is And What It Isn't: It's About Integrating Individual Clinical Expertise And The Best External Evidence. *British Medical Journal.* 1996;312(7023):71-2.
73. Jones CA, Roop SC, Pohar SL, Albrecht L, Scott SD. Translating Knowledge in Rehabilitation: Systematic Review. *Physical Therapy.* 2015;95(4):663-77.
74. Rycroft-Malone J. The PARIHS framework - A framework for guiding the implementation of evidence-based practice. *Journal of nursing care quality.* 2004;19(4):297-304.
75. Canadian Institutes of Health Research. Knowledge Translation – Definition [Internet]. Canadian Institutes of health research; 2016 [Updated 2016-07-28; cited 2016-11-08]. Available from: <http://www.cihr-irsc.gc.ca/e/29418.html#2>
76. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science.* 2009;4(1).
77. Kitson AL, Rycroft-Malone J, Harvey G, McCormack B, Seers K, Titchen A. Evaluating the successful implementation of evidence into practice using the PARIHS framework: Theoretical and practical challenges. *Implementation Science.* 2008;3(1).
78. Jones D. *Sociology and occupational therapy : an integrated approach.* Edinburgh: Churchill Livingstone; 1998.
79. Torres S. Understanding "successful aging": cultural and migratory perspectives [dissertation]. Uppsala: Uppsala University; 2001.
80. Ahmadi F. *Kultur och hälsa [In Swedish].* Lund: Studentlitteratur; 2008.
81. Jackson J, Kennedy BL, Mandel D, Carlson M, Cherry BJ, Fanchiang SP, et al. Derivation and Pilot Assessment of a Health Promotion Program for Mandarin-Speaking Chinese Older Adults. *The International Journal of Aging and Human Development.* 2000;50(2):127-49.
82. Sundell K, Beelmann A, Hasson H, von Thiele Schwarz U. Novel Programs, International Adoptions, or Contextual Adaptations? Meta-Analytical Results From German and Swedish Intervention Research. *Journal of Clinical Child and Adolescent Psychology.* 2015. doi:10.1080/15374416.2015.1020540
83. Durlak JA, DuPre EP. Implementation matters: a review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American journal of community psychology.* 2008;41(3-4):327-50.
84. Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: The new Medical Research Council guidance. *International Journal of Nursing Studies.* 2013;50(5):587-92.
85. Jolley G. Evaluating complex community-based health promotion: Addressing the challenges. *Evaluation and program planning.* 2014;45:71-81.
86. Takeyuki T. International migration: an increasingly pressing global issue. *City Society.* 2007;19:19-35.
87. World Health Organization. What are the public health implications of global ageing? [Internet]. World Health Organization; 2016 [updated September 2011; cited 2016-11-03]. Available from: <http://www.who.int/features/qa/42/en/>
88. Whalley Hammell KR, Iwama MK. Well-being and occupational rights: An imperative for critical occupational therapy. *Scandinavian Journal of Occupational Therapy.* 2012;19(5):385-94.
89. World Health Organization. Health and human rights [Internet]. World Health Organization; [Updated December 2015; cited 2016-11-04]. Available from: <http://www.who.int/mediacentre/factsheets/fs323/en/>
90. Social styrelsen. Vård och omsorg om äldre, lägesrapport [Care of the elderly, situation report](In Swedish). Socialstyrelsen. Falun: Social styrelsen; 2016 [cited 2016-11-03]. Available from: <http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/20088/2016-2-29.pdf>.
91. Löfqvist C, Eriksson S, Svensson T, Iwarsson S: First steps towards evidence-based preventive home visits: Experiences gathered in a swedish municipality. *Journal of Aging Research.* 2012;352942-11. doi:10.1155/2012/352942

92. Hussain-Gambles M, Atkin K, Leese B. Why ethnic minority groups are under-represented in clinical trials: a review of the literature. *Health & Social Care in the Community*. 2004;12(5):382-8.
93. Yin RK. *Case study research: design and methods*. London: SAGE; 2009.
94. Baxter P JS. *Qualitative Case Study Methodology: Study design and Implementation for Novice Researchers*. *The Qualitative Report*. 2008;13(4):544-59.
95. Charmaz K. *Constructing grounded theory: a practical guide through qualitative analysis*. London: SAGE; 2006.
96. Hallberg L. The "core category" of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-Being*. 2006;1(3):141-8.
97. Corbin JM. Taking an Analytic Journey. In: Phyllis Stern JC, Barbara Bowers, Kathy Charmaz, Adele Clark, Janice Morse, editors. *Developing Grounded Theory: The second generation*. Walnut Creek, CA: Left Coast Press; 2008. p. 35-54.
98. Creswell JW. Philosophical assumptions and Interpretive Frameworks. In: Creswell JW, editor. *Qualitative Inquiry and Research Design: Choosing among five approaches*. 3rd ed. Thousand Oaks, California: SAGE publications, Inc.; 2013. p. 15-41.
99. Armstrong R, Waters E, Moore L, Riggs E, Cuervo LG, Lumbiganon P, et al. Improving the reporting of public health intervention research: Advancing TREND and CONSORT. *Journal of Public Health*. 2008;30(1):103-9.
100. Statistik Göteborg. Göteborgs bladet 2016 [Internet]. Göteborg: Statistik Göteborg; 2016 [cited 2016-11-03]. Available from: <http://statistik.goteborg.se/>.
101. Sweden Statistics. Statistical database [Internet]. Örebro; 2016. [Cited 161108]. Available from: <http://www.scb.se>.
102. Lood Q, Gustafsson S, Dahlin-Ivanoff S. Bridging barriers to health promotion: a feasibility pilot study of the 'Promoting Aging Migrants' Capabilities Study'. *Journal of Evaluation in Clinical Practice*. 2015;21(4):604-13.
103. Dahlin-Ivanoff S, Hultberg J. Understanding the multiple realities of everyday life: basic assumptions in focus-group methodology. *Scandinavian Journal of Occupational Therapy*. 2006;13(2):125-32.
104. Sonn U. Longitudinal studies of dependence in daily life activities among elderly persons. *Scandinavian Journal of Rehabilitation Medicine Supplement*. 1996;34:1-35.
105. Hulter Åsberg K. *ADL-trappan* [In Swedish]. Lund: Studentlitteratur; 1990.
106. Folstein MF, Folstein SE, McHugh PR. "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12(3):189-98.
107. Sadler GR, Lee H-C, Lim RS-H, Fullerton J. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing and Health Sciences*. 2010;12(3):369-74.
108. Kitzinger J. Qualitative Research: Introducing focus groups. *British Medical Journal*. 1995;311(7000):299-302.
109. Draucker CB, Martsolf DS, Ross R, Rusk TB. Theoretical Sampling and Category Development in Grounded Theory. *Qualitative health research*. 2007;17(8):1137-48.
110. Ware JE SK, Kosinski M. . SF-36 Health Survey. Manual and Interpretation Guide. Boston: The Health Institute, New England Medical Center; 1993.
111. Krueger RA, Casey MA. *Focus groups: a practical guide for applied research*. Thousand Oaks, Calif: Sage Publications; 2009.
112. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*. 2004;24(2):105-12.
113. Curtin M, Fossey E. Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal*. 2007;54(2):88-94.
114. Stake RE. *The art of case study research*. Thousand Oaks, Calif; London: Sage; 1995.
115. Squires A. Language barriers and qualitative nursing research: Methodological considerations. *International Nursing Review*. 2008;55(3):265-73.
116. Altman D. *Practical statistics for medical research*. London: Chapman & Hall; 1991.
117. Unnebrink K, Windeler J. Sensitivity analysis by worst and best case assessment: Is it really sensitive? *Drug Information Journal*. 1999;33(3):835-9.
118. White IR, Carpenter J, Horton NJ. Including all individuals is not enough: Lessons for intention-to-treat analysis. *Clinical Trials*. 2012;9(4):396-407.
119. Hardy SE, Allore H, Studenski SA. Missing data: A special challenge in aging research. *Journal of the American Geriatrics Society*. 2009;57(4):722-9.

120. Razum O, Spallek J. Addressing health-related interventions to immigrants: migrant-specific or diversity-sensitive? *International Journal of Public Health*. 2014;59(6):893-5.
121. Thomas A, Law M. Research utilization and evidence-based practice in occupational therapy: A scoping study. *American Journal of Occupational Therapy*. 2013;67(4):e55-e65.
122. Chen EK, Reid MC, Parker SJ, Pillemer K. Tailoring Evidence-Based Interventions for New Populations: A Method for Program Adaptation Through Community Engagement. *Evaluation & the Health Professions*. 2013;36(1):73-92.
123. Walter I, Davies H, Nutley S. Increasing research impact through partnerships: Evidence from outside health care. *Journal of Health Services Research and Policy*. 2003;8(2):58-61.
124. Eriksson C, Erikson A, Tham K, Guidetti S. Occupational therapists experiences of implementing a new complex intervention in collaboration with researchers: a qualitative longitudinal study. *Scandinavian Journal of Occupational Therapy*. 2016;1-10.
125. Viswanathan M, Ammerman A, Eng E, Garlehner G, Lohr KN, Griffith D, et al. Community-based participatory research: assessing the evidence. Evidence report/technology assessment (Summary). 2004(99):1-8.
126. Grol R, Grimshaw J. From best evidence to best practice: Effective implementation of change in patients' care. *Lancet*. 2003;362(9391):1225-30.
127. Grimshaw JM, Eccles MP, Lavis JN, Hill SJ, Squires JE. Knowledge translation of research findings. *Implementation Science*. 2012;7(1):50.
128. Blackman T. Defining responsibility for care: Approaches to the care of older people in six European countries. *International Journal of Social Welfare*. 2000;9(3):181-90.
129. Graham M. Emotional Bureaucracies: Emotions, Civil Servants, and Immigrants in the Swedish Welfare State. *Ethos*. 2002;30(3):199-226.
130. Ekman A, Vass M, Avlund K. Preventive home visits to older home-dwelling people in Denmark: are invitational procedures of importance?: Preventive home visits to older home-dwelling people in Denmark. *Health & Social Care in the Community*. 2010;18(6):563-71.
131. Matthews A, Brennan G, Kelly P, McAdam C, Mutrie N, Foster C. "don't wait for them to come to you, you go to them". A qualitative study of recruitment approaches in community based walking programmes in the UK. *BMC Public Health*. 2012;12(1):635-.
132. Behm L, Zidén L, Dunér A, Behm L, Falk K, Dahlin-Ivanoff S, et al. Multi-professional and multi-dimensional group education- a key to action in elderly persons. *Disability and Rehabilitation*. 2013;35(5):427.
133. Turner G, Shepherd J. A method in search of a theory: Peer education and health promotion. *Health Education Research*. 1999;14(2):235-47.
134. Kocken PL, Voorham AJJ. Effects of a peer-led senior health education program. *Patient Education and Counseling*. 1998;34(1):15-23.
135. Whalley Hammell KR. Client-centred occupational therapy: the importance of critical perspectives. *Scandinavian Journal of Occupational Therapy*. 2015;22(4):237-43.
136. Alharbi TSJ, Carlström E, Ekman I, Jarneborn A, Olsson L-E, et al. Experiences of person-centred care - patients' perceptions: qualitative study. *BMC Nursing*. 2014;13(1):28-.
137. Jormfeldt H, Rask M, Brunt D, Bengtsson A, Svedberg P, et al. Experiences of a person-centred health education group intervention: A qualitative study among people with a persistent mental illness. *Issues in Mental Health Nursing*. 2012;33(4):209.
138. Fors A. Personcenterade samtal inom hälsopromotivt arbete. In: Ekman I, editor. *Personcentrerad inom hälso- och sjukvård: från filosofi till praktik [Person-centeredness in health-care services: from philosophy to practice](In Swedish)*. Stockholm: Liber; 2014. p. 226-43.
139. Walter I, Nutley S, Davies H. Developing a Taxonomy of Interventions used to Increase the Impact of Research. Discussion paper 3. University of St Andrews: Research Unit for Research Utilisation; 2003.
140. Lood Q. Discovering the capabilities of ageing persons who are born abroad: crossing norms, moving health promotion forward [dissertation on the internet]. Göteborg: University of Gothenburg; 2015 [cited 2016 Nov 05]. Available from: https://gupea.ub.gu.se/bitstream/2077/37526/1/gupea_2077_37526_1.pdf
141. Capalb DJ, O'Halloran P, Liamputtong P. Why older people engage in physical activity: an exploratory study of participants in a community-based walking program. *Australian Journal of Primary Health*. 2014;20(1):74-8.
142. Povlsen L. Immigrant women's clubs in a health-promotion perspective. *Scandinavian Journal of Public Health*. 2012;40(4):355-9.

143. Johansson K, Rudman DL, Mondaca M, Park M, Luborsky M, Josephsson S, et al. Moving Beyond 'Aging In Place' to Understand Migration and Aging: Place Making and the Centrality Of Occupation. *Journal of Occupational Science*. 2013;20(2):108-19.
144. Fänge A, Dahlin-Ivanoff S. The home is the hub of health in very old age: Findings from the ENABLE-AGE Project. *Archives of Gerontology & Geriatrics*. 2009;48(3):340-5.
145. Kulla G, Ekman S-L, Sarvimäki A. Experiential Health from an Ageing and Migration Perspective: The Case of Older Finland-Swedes. *Journal of Immigrant and Minority Health*. 2010;12(1):93-9.
146. Sørensen K, Van Den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, et al. Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*. 2012;12(1):80-.
147. Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine*. 2011;155(2):97-107.
148. Levasseur M, Carrier A. Integrating health literacy into occupational therapy: Findings from a scoping review. *Scandinavian Journal of Occupational Therapy*. 2012;19(4):305-14.
149. Stuck A. Whom do preventive home visits help? *Journal of American Geriatrics Society*. 2008;56(3):561-3.
150. Gustafsson S, Edberg A-K, Johansson B, Dahlin-Ivanoff S. Multi-component health promotion and disease prevention for community-dwelling frail elderly persons: a systematic review. *European Journal of Ageing*. 2009;6:315-29.
151. Pudarc S, Sundquist J, Johansson SE. Country of birth, instrumental activities of daily living, self-rated health and mortality: a Swedish population-based survey of people aged 55-74. *Social science & medicine* (1982). 2003;56(12):2493-503.
152. Torres S. Understandings of successful ageing in the context of migration: The case of Iranian immigrants in Sweden. *Ageing and Society*. 2001;21(3):333-55.
153. Law MC, Baum CM, Dunn W. Measuring occupational performance: supporting best practice in occupational therapy. Thorofare, N.J: SLACK Inc; 2005.
154. Baptiste S, Law, M., Pollock, N., Polatajko, H., McColl, M.A. & Carswell, A. (1993) The Canadian Occupational Performance Measure. *World Federation of Occupational Therapy Bulletin*, 28, 47-51.
155. Turner-Stokes L. Goal attainment scaling (GAS) in rehabilitation: a practical guide. *Clinical Rehabilitation*. 2009;23(4):362-70.
156. Mortenson WB, Oliffe JL. Mixed methods research in occupational therapy: A survey and critique. *OTJR Occupation, Participation and Health*. 2009;29(1):14-23.
157. Creswell JW. *Research design : qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, Calif.: Sage; 2009.
158. Onwuegbuzie AJ, Johnson RB, Collins KMT. Assessing legitimation in mixed research: a new framework. *Quality & Quantity*. 2011;45(6):1253-71.
159. Whalley Hammell KR. Using Qualitative Research to Inform the Client-Centred Evidence-Based Practice of Occupational Therapy. *The British Journal of Occupational Therapy*. 2001;64(5):228-34.
160. Temple B. Crossed Wires: Interpreters, Translators, and Bilingual Workers in Cross-Language Research. *Qualitative health research*. 2002;12(6):844-54.
161. Xue Q-L. The Frailty Syndrome: Definition and Natural History. *Clinics in Geriatric Medicine*. 2011;27(1):1-15.
162. McKenzie JF, Neiger BL, Thackeray R. Interventions. In: McKenzie JF, Neiger BL, Thackeray R, editors. *Planning, implementing, and evaluating health promotion programs: a primer*. San Francisco: Pearson/Benjamin Cummings; 2013. p. 205-254.
163. May CR, Johnsson M, Finch T. Implementation, context and complexity. *Implementation Science*. 2016; 11(1).